Employee ID: _____

CITY OF NEW ORLEANS – HEALTH CARE PLAN
Change of Status Form for **Active Employees** and **Retirees**

PLEASE PRINT OR TYPE

LAST NAME FIRST NAME MIDDLE INITIAL SOCIAL SECURITY NO.

_____

CHANGE MY ADDRESS TO:

ADDRESS_____CITY_____STATE_____ZIP_____

CHANGE MY NAME TO:

LAST NAME _____ FIRST _____ MIDDLE_____

INSTRUCTIONS

Newborn children, adopted children, or new spouse must be added to your healthcare coverage within 60 days of the date of birth, date of adoption, or marriage. Employees/Retirees are allowed an additional 30 days to provide the **Original Birth Certificate and Social Security Card** for newborns must be submitted to your HR Manager to avoid cancellation of coverage. If you declined coverage for a dependent during Open Enrollment and declare in writing that your dependent(s) had coverage under another plan, the dependent may be added later under special enrollment within 30 days after the termination of coverage from other plans. Otherwise, additions can only be made during the city's Open Enrollment.

All healthcare coverage is pre-taxed, which means you can only make changes to your coverage during Open Enrollment. Any changes made during Open Enrollment will become effective the following January. The only exception is when the change is the result of a change in family status. A change in family status includes marriage, divorce, death of spouse or child, birth or adoption of a child and termination of employment of spouse.

NOTE: ALL EMPLOYEES HEALTHCARE DEDUCTIONS ARE PRE-TAXED. RETIREES ARE POST-TAXED.

Do you want to make a change in your Health Care Plan: [ ] **Yes** [ ] **No**

Which plan would you like to enroll into? **UHC Health Base Plan** [ ] OR **UHC Health Buy-Up Plan** [ ]

CHANGE COVERAGE TO:
_____ No change to coverage
_____ Employee/Retiree only
_____ Employee/Retiree and Spouse
_____ Employee/Retiree and Dependent Children
_____ Employee/Retiree, Spouse and Dependent Children
_____ CANCEL COVERAGE

ADD the following dependents:

FULL NAME DATE OF BIRTH (month/day/year) RELATIONSHIP SOCIAL SECURITY NO.

_____

_____

_____

If adding spouse, provide date of marriage: _____.
Is your spouse presently a member of a group health plan? If yes, give name and address of spouse's group health plan.

Company Name_____ Contact Number (s) _____

If you are adding a spouse and/or children during the enrollment period; give the name of spouse's former employer, address and date of termination.

_____

_____

DROP the following dependents:

FULL NAME	RELATIONSHIP	SOCIAL SECURITY NO.

Is a spouse being dropped because of a divorce? _____Yes ____No
Provide date of divorce and a copy of the divorce decree, if applicable: _____

Provide estranged spouse's current address: _____

Employee/Retiree's Signature: _____

Date Signed: _____Department: _____

Address: _____

Telephone No: _____ Email Address: _____

HUMAN RESOURCE APPROVAL_____

Mail form to: **Chief Administrative Office, Benefits Administration Division, Room 9E06, City Hall, 1300 Perdido Street, New Orleans, LA 70112**

Office use only

____ADP ____UHC ____ACCESS
Date Received _____
Date Processed_____
Processor_____

Rev. 9/18/2023