



As easy as 1-2-3



Family Status Change Form

You must complete and sign this form and return it to the address printed on the back of this form within 31 days of a family status change. This form must be RECEIVED within 31 days of experiencing a family status change.

It is your responsibility to ensure this form is received within the correct time frame in order to make the change(s) requested below. Enrolling a Domestic Partner requires completion and approval of a Statement of Domestic Partnership.

EMPLOYEE INFORMATION

NAME (FIRST, MIDDLE INITIAL, LAST) SOCIAL SECURITY #
ADDRESS (STREET/BOX NO.) CITY/STATE/ZIP PHONE #

FAMILY STATUS CHANGE

REASON FOR CHANGE (check one below & provide date)

Effective date: (MUST HAVE EFFECTIVE DATE TO ENTER CHANGE)

FOR HUMAN RESOURCES USE ONLY
Event Date: Event Number:
Event Name:

- Marriage
Divorce, legal separation, or end of a domestic partner relationship
Birth, adoption, or receiving custody of children
Death of your spouse, domestic partner, or a dependent child
A dependent becomes ineligible for coverage
Your spouse or domestic partner gains or loses coverage at his or her job, or there is a significant change in your spouse's or domestic partner's coverage
You switch between full-time and part-time employment
Other (Explain)

MY CHOICES ELECTION CHANGES

MEDICAL PLAN OPTION:

- EPO
PPO
Basic
Cancel Coverage

MEDICAL PLAN COVERAGE CATEGORY:

- 1. Employee Only
2. Employee & Spouse
3. Employee & Child(ren)
4. Employee & Spouse & Child(ren)
5. Employee & Domestic Partner
6. Employee & Domestic Partner & Child(ren)

DENTAL PLAN OPTION:

- Elect Coverage
Cancel Coverage

DENTAL PLAN COVERAGE CATEGORY:

- 1. Employee Only
2. Employee & Spouse
3. Employee & Child(ren)
4. Employee & Spouse & Child(ren)
5. Employee & Domestic Partner
6. Employee & Domestic Partner & Child(ren)

VISION PLAN OPTION:

- Elect Coverage
Cancel Coverage

VISION PLAN COVERAGE CATEGORY:

- 1. Employee Only
2. Employee & Spouse
3. Employee & Child(ren)
4. Employee & Spouse & Child(ren)
5. Employee & Domestic Partner
6. Employee & Domestic Partner & Child(ren)

HEALTH CARE/DEPENDENT CARE SPENDING ACCOUNT CHANGE

HEALTH CARE SPENDING ACCOUNT

DEPENDENT CARE SPENDING ACCOUNT

Change to \$ per pay period

Change to \$ per pay period

SUPPLEMENTAL LIFE CHANGE

EMPLOYEE SUPPLEMENTAL LIFE

SPOUSE SUPPLEMENTAL LIFE
(DOMESTIC PARTNERS ARE NOT
ELIGIBLE FOR SUPPLEMENTAL LIFE)

CHILD(REN) SUPPLEMENTAL LIFE

\$ OF COVERAGE You may elect any amount between \$10,000 and \$500,000 in Employee Supplemental Life Insurance. If you elect to increase your Employee Supplemental Life Insurance, you will be required to complete and submit an Evidence of Insurability form, which will be provided with your confirmation statement.

\$ OF COVERAGE You may elect any amount between \$10,000 and \$500,000 in Spouse Supplemental Life Insurance. If you elect to increase your Spouse Supplemental Life Insurance, you will be required to complete and submit an Evidence of Insurability form, which will be provided with your confirmation statement.

\$ OF COVERAGE You may elect one of the following amounts: \$2,500, \$5,000, \$7,500, or \$10,000.

LONG-TERM DISABILITY CHANGE

OPTION 1 – 50% of pay to a maximum of \$5,000

OPTION 2 – 60% of pay to a maximum of \$10,000

DEPENDENT CHANGE

Please indicate if you are adding, deleting, or changing a dependent's information. For additional entries, use additional form.

Under Relationship, please use SP = Spouse; D = Daughter; S = Son; or DP = Domestic Partner.

A, D, C*	FIRST	MI	LAST	SSN	BIRTH DATE	GENDER	RELATIONSHIP	MEDICAL	DENTAL	VISION

*A = ADD; D = DELETE; C = CHANGE

BENEFICIARY CHANGE

If you wish to make changes to your Beneficiaries, please complete and submit a new Beneficiary Form.

I have received and understand the terms and conditions of the programs I have elected on this form. My signature below authorizes the necessary deductions from my earnings for the plans I have marked. I declare all the above information to be true and correct. I understand that if any information is not true and correct, Rural/Metro reserves the right to take disciplinary action up to and including termination. I agree to provide notification of any change in status within 31 days of the change.

EMPLOYEE SIGNATURE _____

DATE _____

MY CHOICE ADMINISTRATION APPROVAL _____

DATE _____

A confirmation of the changes submitted on this form will be sent to you in the mail. You may not make any further changes to your *My Choice* selections unless you have another family status change.

Complete and sign this form and Statement of Domestic Partnership (if applicable) and return to:

Rural/Metro Corp.
Attn: Corporate Benefits

9221 E. Via De Ventura
Scottsdale, AZ 85258
(888) 301-2123 PHONE
(480) 606-3539 FAX