



NEW YORK MEDICAL COLLEGE

Human Resources

Valhalla, New York 10595 Tel 914-594-4560 Fax 914 594-4309

QUALIFYING EVENT FORM

MUST BE SUBMITTED WITHIN 31 DAYS OF THE DATE OF THE EVENT

EMPLOYEE NO. _____ SOC. SEC. NO. _____

NAME: _____

Last

First

Middle Initial

CURRENT ADDRESS: _____

City

State

Zip Code

DATE OF BIRTH: _____ EMPLOYEE CLASS: _____

QUALIFYING EVENT: (Check the appropriate box)

- * [] Marriage, divorce, legal separation, or annulment
- * [] Birth or adoption of a child
- * [] Loss of eligibility or death of a dependent
- * [] You/your spouse beginning/changing/ending a job which results in a gain or loss of medical coverage
- * [] Return to full-time student status

***ATTACH/FORWARD COPY OF APPLICABLE CERTIFICATE/DOCUMENTATION**

Dependent's Name: _____

Dependent's Address: _____

Dependent's SSN: _____ Date of Birth: _____

Reason: _____

DATE OF QUALIFYING EVENT: _____

EMPLOYEE'S SIGNATURE: _____ DATE: _____

REVIEWED BY: _____ DATE: _____