THE SCHOOL DISTRICT OF PHILADELPHIA

Office of Employee Benefits
Phone: (215) 400-4630
Fax: (215) 400-4631
benefits@philasd.org

# Request to Remove a Dependent

Benefits changes as a result of a qualifying life event are accepted during the year if they are received by the Benefits Office within 30 days of the qualifying event date. Examples of qualifying life events are birth of a child, marriage, divorce, adoption, loss/gain of other health insurance. Proof of the event is required. Benefits changes without a qualifying event can only be made during our Annual Open Enrollment, held in May with Benefit changes effective July 1.

Note: The District has the right to bill you and pursue collection for the full cost of coverage provided to any ineligible dependent. If you do not remove the ineligible dependent from coverage and they are later found to NOT be eligible for coverage, you may be billed for costs associated with coverage and may face disciplinary action up to and including termination.

| Employee Name | Employee ID | Social Security Number | Union |
|---|---|---|---|
| | | | |

- Select the plan(s) from which you wish to remove a dependent **Note: Employees represented by **PFT or 634** must contact their respective union to remove dental, prescription & vision benefits, as they are provided through the union.* ***1201 members must contact their local and national union to remove a dependent(s) from all coverage as they are provided through the union.***

☐ Medical
☐ Prescription*
☐ Dental*
☐ Vision*

- List the names and required information of all dependent(s) to be removed

| Name of Dependent | Relationship | Date of Birth | Social Security Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Qualifying Event:** check appropriate reason and effective date. Please provide documentation such as divorce decree, death certificate, proof of new insurance enrollment or birth certificate.

☐ Divorce ___/___/_____
☐ Death ___/___/_____
☐ New coverage through other provider. ___/___/_____
☐ Other, please specify:_____

If different from your employee mailing address, provide an address for us to mail COBRA election materials for eligible removals.

Name: _____
Address Line 1 _____
City _____
State _____ Zip code _____

**READ AND SIGN:** I understand I am responsible for submitting proof of the qualifying life event in order for my request to be processed within 30 days of the event. I understand when you remove an eligible dependent s/he cannot be re-enrolled except within 30 days of a new qualifying event or during the annual open enrollment held in May for a July 1 effective date.

**Employee Signature:** _____ **Date:** _____

**FOR OFFICIAL USE ONLY:** ☐**Term SDP** (Plan-Tier_____/Dent/RX/Exp Dt_____) (ENRL/DPND)