NJ Tax$ave
Horizon*MyWay*®
CHANGE IN LIFE EVENT FORM

Horizon

Group Name: STATE OF NEW JERSEY **Horizon Group Number: 601050**

Employer Agency: ☐ **Centralized Payroll (0001)** ☐ **Legislative Group (0002)** ☐ **Rutgers State University (1229)**
☐ **NJIT - New Jersey Institute of Technology (1285)** ☐ **Ramapo College (1812)** ☐ **College of New Jersey (1820)**
☐ **Thomas Edison State University (1821)** ☐ **Stockton University (1822)** ☐ **New Jersey City University (1823)**
☐ **WM Paterson University (1824)** ☐ **Rowan University (1825)** ☐ **Montclair University (1826)** ☐ **Kean University (1832)**
☐ **New Jersey Building Authority (8005)** ☐ **UNH - University Hospital (8157)** ☐ **Palisade Interstate Park Commission (9910)**

Employee Information (Please Print)	**Spending Account ID #**
Last Name / First Name / Middle Initial	**S** **A**
Street Address	**Social Security #** (if SA# is not known)
City / State / Zip	**Daytime Phone #**

Qualifying Event Information

I have experienced a change in status as indicated below. The effective date of change is: _____
(You have a limited time period to submit this change. Discuss with your benefits department to determine the time period.)

Change affects: ☐ **Self** ☐ **Spouse** ☐ **Dependent**

1. Employment Status Change
☐ Termination of employment ☐ Full-time to Part-time ☐ Leave of Absence (unpaid)
☐ Commencement of employment ☐ Part-time to Full-time ☐ Change in work status of spouse
☐ Continuation through COBRA (for Medical Expense Reimbursement Only) ☐ Significant change in health coverage due to spouse's employment

2. Marital Status Change ☐ Marriage ☐ Legal Separation ☐ Divorce ☐ Widowed

3. Dependent Status Change ☐ Birth ☐ Adoption ☐ Death

4. Other: _____

Due to the Qualifying Event indicated above, I am requesting that my Horizon enrollment for this plan year be changed.
(Election amounts cannot be lowered if your employee (self) is terminating employment)

		Current Annual Election
From:	☐ Medical Expense	$ _____
	☐ Dependent/Day Care Expense	$ _____
		New Annual Election
To:	☐ Medical Expense	$ _____
	☐ Dependent/Day Care Expense	$ _____

Pay Cycle: ☐ 10 Months ☐ 12 Months

Employee Signature - Not required for terminating employees (self)

I certify that the status change as noted above has occurred. I authorize that my enrollment records be changed or cancelled as requested.

_____ _____ _____
Employee's Signature Print Name Date

Group Signature

_____ _____
Group Signature Date

Questions? Call Group Leader Services at 1-888-215-0025.

Send via secured email only:
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