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

2027 Plan Year

Horizon

Group Name: STATE OF NEW JERSEY

Employer Agency: ☐ **Centralized Payroll (000100)** ☐ **Legislative Group (000200)** ☐ **Rutgers State University (122900)** ☐ **NJIT - New Jersey Institute of Technology (128500)** ☐ **Ramapo College (181200)** ☐ **College of New Jersey (182000)** ☐ **Thomas Edison State University (182100)** ☐ **Stockton University (182200)** ☐ **New Jersey City University (182300)** ☐ **William Paterson University (182400)** ☐ **Rowan University (182500)** ☐ **Montclair University (182600)** ☐ **Kean University (183200)** ☐ **New Jersey Building Authority (800500)** ☐ **UNH - University Hospital (815700)** ☐ **Palisade Interstate Park Commission (991000)**

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 1-877-765-8811.

Send via secured email only:
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