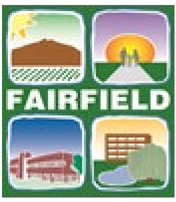


CITY OF FAIRFIELD

QLE – Loss of Other Coverage (For Employee or Dependent)

EMPLOYEE INFORMATION

Name: ______________________ Emp ID#: ______________________

Date: ______________________ Phone: ______________________

Complete this form if you are requesting a change to your benefits due to a loss of other health coverage for yourself or eligible dependent. This form must be submitted within 30 days of the date coverage ends. Late submission may result in needing to wait until the next Open Enrollment period.

Date of loss of coverage: ____________________________

You may add yourself and any eligible dependents to your benefit plans at this time. Eligible dependents are defined as your spouse, domestic partner, natural child, stepchild, adopted child, and your domestic partner's child.

Relationship Code: **SP** = Spouse **DP** = Domestic Partner
C= Natural/Step/Adopted Child **DC** = Domestic Partner's Child

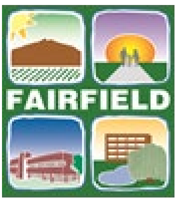
Benefit Code: **M** = Medical **D** = Dental **V** = Vision

In addition to yourself, please list all eligible dependents and select which benefit you would like to add them to:

Name	Code	Gender	DOB	SSN#	Benefit		
	Self				**M**	**D**	**V**
					M	**D**	**V**
					M	**D**	**V**
					M	**D**	**V**
					M	**D**	**V**
					M	**D**	**V**

Important: You must submit supporting documentation for self and/or the eligible dependent losing coverage.

Supporting documentation must be a letter/document from spouse/domestic partner's employer, insurance carrier, or program administrator that includes names of individuals losing coverage, type of coverage, and date coverage ended.



CITY OF FAIRFIELD

QLE – Loss of Other Coverage (For Employee or Dependent)

In addition to adding yourself/dependents to your benefits (e.g., medical, dental, or vision), you may also elect to change your current provider/plan for that benefit.

Provider/plan changes are only allowed when adding an eligible dependent to that plan. For a summary of each plan's benefits and current premium rates, please refer to the **Benefits Guide.**

If you are enrolling for the first time or requesting to change plans in addition to adding a dependent, please complete the Benefit Plan Change section below for the relevant plans. If you want your dependents added to your current plans, you do not need to fill out the Benefit Plan Change Section.

Benefit Plan Change:	
Medical	
	Current Plan Name:
	New Plan Name:
Dental	
	Current Plan Name:
	New Plan Name:
Vision	
	Current Plan Name:
	New Plan Name:

Please email benefits@fairfield.ca.gov the completed form or with any questions/concerns you may have.