CITY OF FAIRFIELD

QLE – Gain 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 **gain of other health coverage** for yourself or eligible dependent. This form must be submitted within 30 days of the date coverage begins. Late submission may result in needing to wait until the next Open Enrollment period.

Date gained coverage: _____

You may remove yourself and any eligible dependents from 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

Please provide information for self/eligible dependents and which benefits you/they should be removed from:

Name	Code	Gender	DOB	SSN#	Benefit		
	Self				☐ M	☐ D	☐ V
	Select				☐ M	☐ D	☐ V
	Select				☐ M	☐ D	☐ V
	Select				☐ M	☐ D	☐ V
	Select				☐ M	☐ D	☐ V
	Select				☐ M	☐ D	☐ V

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

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

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In addition to removing dependents from 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 removing an eligible dependent from that plan. For a summary of each plan's benefits and current premium rates, please refer to the **Benefits Guide.**

If you're requesting to change plans in addition to removing a dependent, please complete the Benefit Plan Change section below for the relevant plans. If you want your dependents removed from your current plans, but are not making changes to your current plans, you do not need to fill out the Benefit Plan Change Section.

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

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