QUALIFYING LIFE EVENT CHANGE REQUEST

Name: _____ **Employee #** _____

Event Reason:
____ Birth, adoption or legal guardianship of child(ren)
____ Marriage
____ Divorce or legal separation
____ Gained other coverage
____ Loss of other coverage
____ Other (please specify) _____

Event Effective Date: _____

(check appropriate box)

Name	Relationship	Birth Date	Social Security Number	(A)dd or (R)emove	Medical*	Dental*	Vision

***When adding coverage, indicate your medical plan / dental plan option, if applicable.**

In order for your enrollment or cancellation of benefits to be effective, proof of the life event must be attached. For example, marriage and/or birth certificates (hospital records) are required in order for you to enroll your newly eligible dependents.

For additional information on qualifying life events, log onto the life event page located on www.alliedUniversalbenefits.com. To review plan options and cost impact of your changes, log onto your on-line enrollment record at https://ehub.aus.com/OE and click on See how a qualified life event may affect benefit pricing.

I understand it is unlawful for my dependents or me to knowingly provide false, incomplete or misleading facts or information to Allied Universal for the purpose of defrauding or attempting to defraud. Penalties may result in loss, delay or reduction of coverage, ineligibility to enroll in plans, repayment of benefits paid on your behalf and/or discipline up to and including termination of your employment. I understand and acknowledge that under the Allied Universal Section 125 Plan, benefits are deducted on a pre-tax basis. I hereby elect to have the Company redirect my salary on a pre-tax basis during the Plan Year and apply this amount toward the purchase of the health coverage I have designated above. I further understand and acknowledge: that because my taxable compensation will be reduced due to my participation in the Allied Universal my social security benefits may be reduced; that my health coverage and/or cost of health coverage may be changed from time to time due to a change in my title, job site or change in rates; that my election cannot be changed unless I experience a qualifying life event; that if my benefits are made effective retroactive to the first of the month, I may incur missed payroll deductions.

Employee Signature: _____ Daytime Phone Number _____Date: _____

THIS FORM AND THE REQUIRED DOCUMENTATION MUST BE RECEIVED WITHIN 31 DAYS OF THE EVENT. YOUR CHANGE(S) WILL BECOME EFFECTIVE ON THE 1ST OF THE MONTH FOLLOWING RECEIPT OF NOTIFICATION WITH THE EXCEPTION OF BIRTH/ADOPTION (WHICH WILL BE EFFECTIVE ON THE EVENT DATE). YOU MAY MAIL, EMAIL OR FAX THIS FORM WITH THE REQUIRED DOCUMENTATION TO THE ADDRESS BELOW:

Allied Universal – Attn: Benefits Department
161 Washington Street – Suite 600
Conshohocken, PA 19428

Benefits Hotline 888-670-7106
EMAIL: Benefits@aus.com FAX 888-207-1420