

# CHANGE IN MARITAL STATUS NOTIFICATION & CONTINUATION OF COVERAGE REQUEST

CO-1319 New 5/2012



**EMPLOYEES: FORWARD TO YOUR AGENCY PAYROLL/HUMAN RESOURCES OFFICE**  
**RETIREES: RETURN TO RETIREMENT HEALTH UNIT, HEALTHCARE POLICY & BENEFIT SERVICES DIVISION**

<b>EMPLOYEE/RETIREE NAME</b> (Last Name, First Name, MI)	<b>EMPLOYEE NUMBER</b>	<b>DATE OF BIRTH</b>
<b>HOME ADDRESS</b>	<b>PERSONAL E-MAIL ADDRESS</b>	
<b>HOME/CELL PHONE NUMBER</b> (     )     -	<b>EMPLOYING AGENCY NAME/ADDRESS</b>	

## REQUEST FOR CONTINUATION OF COVERAGE

The person listed below has been enrolled as a dependent on my state-sponsored health coverage. I am reporting a change in my marital status and request continuation of health benefit coverage for my spouse/former spouse for up to 3 years or until either party remarries, whichever first occurs. I understand that the cost of providing continuation coverage will be entirely at my expense or that the fair market value of health benefit coverage will be reported as income to me for state and federal tax purposes. I certify that I have not remarried.

CHANGE IN STATUS	PRINT NAME OF FORMER SPOUSE	DATE OF JUDGMENT
<input type="checkbox"/> I was granted a judgment of legal separation prior to July 1, 2012. (Fair market value taxable to employee.)		Prior to 7/1/2012
<input type="checkbox"/> I was granted a judgment of legal separation after July 1, 2012. (100% of cost is payable by employee/member.)		____ / ____ / ____
<input type="checkbox"/> I was divorced before July 1, 2012, and the divorce decree requires that I continue health benefit coverage for my former spouse. (100% of cost is payable by employee/member.)		Prior to 7/1/2012
<input type="checkbox"/> I was divorced after July 1, 2012, and the divorce decree requires that I continue health benefit coverage for my former spouse. (100% of cost is payable by employee/member.)		____ / ____ / ____

<b>EMPLOYEE SIGNATURE</b>	<b>DATE</b>
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### THIS SECTION TO BE COMPLETED BY AUTHORIZED AGENCY PERSONNEL

Is this employee currently enrolled in or eligible for a state-sponsored Medical Plan?     YES     NO

<b>Preparer's Name</b>	<b>Date</b>
<b>Preparer's Signature</b>	<b>Preparer's E-Mail</b>