[Date]

[Employee Name]
[Address Line 1]
[City, State, Zip Code]

Subject: Newborn and Adoption Life Event Coverage Adjustment Questionnaire

Dear [Employee Name],

Congratulations on the new addition to your family. We have received your request to adjust your health insurance and benefit coverage due to a qualifying life event (Newborn/Adoption).

To finalize the adjustment to your policy, please complete the following questionnaire and return it to the Human Resources Department within [Number] days of receipt.

Part 1: Event Information

Type of Event: [ ] Birth [ ] Adoption [ ] Legal Placement

Date of Event (Birth or Placement): _____

Full Name of Child: _____

Part 2: Coverage Adjustments

Requested Benefit Changes (Check all that apply):

- [ ] Medical Insurance
- [ ] Dental Insurance
- [ ] Vision Insurance
- [ ] Dependent Care Flexible Spending Account (FSA)
- [ ] Supplemental Life Insurance

Part 3: Required Documentation

Please confirm you have attached the following (Check one):

- [ ] Hospital Discharge Papers / Birth Certificate
- [ ] Adoption Decree / Legal Placement Papers
- [ ] Social Security Number (If not yet available, please provide within 90 days)

Part 4: Employee Attestation

I certify that the information provided above is true and accurate. I understand that these changes must be submitted within the enrollment window allowed by the plan.

Employee Signature: _____ Date: _____

If you have any questions regarding your benefits or the documentation required, please contact [Department Name] at [Phone Number] or [Email Address].

Sincerely,

[Sender Name]
[Title]
[Company Name]