



Benefits Change Form

Please Complete Applicable Sections in Full

EMPLOYEE INFORMATION										
EMPLOYEE NAME					SOCIAL SECURITY NUMBER					
EMPLOYER NAME			PLAN NAME			PAY GROUP/PLAN NUMBER				
NAME CHANGE				ADDRESS CHANGE						
<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT				CURRENT ADDRESS						
FORMER NAME				CITY			STATE		ZIP	
NEW NAME				NEW ADDRESS						
REASON FOR CHANGE (MARRIAGE, DIVORCE, CORRECTION ,ETC.)				CITY			STATE		ZIP	
CHANGE IN COVERAGE OR PRIMARY CARE PHYSICIAN										
<input type="checkbox"/> CHANGE TO FAMILY PLAN		<input type="checkbox"/> CHANGE TO INDIVIDUAL PLAN		DATE	REASON				EFFECTIVE DATE OF CHANGE	
<input type="checkbox"/> ADD SPOUSE OR DEPENDENT(S) <input type="checkbox"/> DELETE SPOUSE OR DEPENDENT(S) <input type="checkbox"/> CHANGE PCP				EFFECTIVE DATE OF CHANGE				EFFECTIVE DATE OF COVERAGE		
LAST NAME	FIRST NAME	MD INIT	SOCIAL SECURITY #	BIRTHDATE			SEX		*RELATIONSHIP TO INSURED	SELECT OR CHANGE PRIMARY CARE PHYSICIAN (LAST NAME, FIRST INITIAL)
				MO	DAT E	YEAR	M/F			
<input type="checkbox"/> SPOUSE HAS OTHER INSURANCE COVERAGE (THIS PLAN IS SECONDARY)					<input type="checkbox"/> SPOUSE HAS <u>NO</u> OTHER INSURANCE COVERAGE					
<input type="checkbox"/> DEPENDENT(S) HAVE OTHER INSURANCE COVERAE (THIS PLAN IS SECONDARY)					<input type="checkbox"/> DEPENDENT(S) HAVE <u>NO</u> OTHER INS. COVERAGE					
LIST OTHER INSURANCE COVERAGE:										
NAME OF CARRIER								EFFECTIVE DATE OF CHANGE		
ADDRESS OF CARRIER								EFFECTIVE DATE OF COVERAGE		
TERMINATION OF COVERAGE										
Check Applicable Box <input type="checkbox"/> TERMINATION OF COVERAGE <input type="checkbox"/> TERMINATION OF EMPLOYMENT								EFFECTIVE DATE OF TERMINATION		
SIGNATURES REQUIRED										
EMPLOYEE'S SIGNATURE								DATE		
EMPLOYER'S SIGNATURE								DATE		
* Dependency Statement required if last name is different than contract holder's or dependent is not a natural child										