REQUEST FOR EMPLOYEE CHANGE

Employer: ____ **Group #:** _____________

Employee Name: _______________________________**Soc. Sec. #** _____________________________

1. I wish to make the following changes to my health coverage:

☐ **Add Dependent Coverage for the following (*List Dependents to be added*):**

Dependent Name	Soc. Sec. #	Sex	Date of Birth	Relationship

Reason for Addition: (Change in family status)

☐ Marriage ☐ Spouse loss of Job ☐ Adoption

☐ Birth ☐ Other ____

Date of Change: _______________________

2. Decrease or Terminate Dependent coverage (**List Dependent(s) to be dropped)**

Dependent Name	Soc. Sec. #	Sex	Date of Birth	Relationship

Reason:____**Effective Date of Change**:____________

I understand I will be bound by this election and can only add coverage later if my situation is a life change event that is permitted by the IRS Code Section 125, HIPAA regulations.

3. Cancel Coverage:

Reason: ____ Date: ______________

4. Change Life Insurance Beneficiary to: ____

5. Change Life Insurance Amount to: ____

6. Change Employee's Name to:____ ___________

7. Other Change: (***Explain - Division or Address, etc.***)

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Employee Signature: ____ **Date:** ________________

Company Representative ____ **Date:** ________________

Authorized Signature