BENEFIT STATUS CHANGE FORM

EMPLOYEE INFORMATION

Name	
Employee ID #	Work Location and Extension
Address	Phone Number
City	State Zip
Event Date	HR Use:

CHANGE OF STATUS (PLEASE CHECK WHICH APPLIES):

Proof Required-Attach Documentation

- ❑ Marriage
- ❑ Birth or adoption
- ❑ Employee gains or loses coverage
- ❑ Spouse gains or loses coverage
- ❑ Dependent gains or loses coverage
- ❑ Legal separation
- ❑ Increase or decrease in hours
- ❑ Court order to add/drop coverage for a dependent
- ❑ Civil Union
- ❑ Start or return of FMLA
- ❑ Divorce
- ❑ Start or return of unpaid leave of absence
- ❑ Gain or loss of Student Status
- ❑ Gain or loss of outside medical coverage
- ❑ Gain or loss of other dependent's eligibility
- ❑ Death of spouse or dependent
- ❑ Change in cost
- ❑ Change in dependent care provider

COMMENTS____

REQUESTED CHANGE TO COVERAGE

❑ ADD EMPLOYEE AND/OR DEPENDENTS ❑ REMOVE EMPLOYEE AND/OR DEPENDENTS

Name	Social Security #	Relationship	Gender	DOB	Disabled Dependent Y/N	FT Student* Y/N	Medical Plan Y/N	Dental Plan Y/N

*Full-Time student status over age 19 required for Dental enrollment

CHANGE OF LIFE INSURANCE BENEFICIARY DESIGNATION ❑**Primary** ❑ **Contingent**

Please provide full name and relationship. If designating more than one beneficiary, please indicate BY PERCENTAGE how you want your benefit divided.

____

Name SSN# Relationship Date of Birth Percentage % Primary **OR** Contingent

____

Name SSN# Relationship Date of Birth Percentage % Primary **OR** Contingent

If you have additional beneficiaries please attach a separate sheet of paper.

❑**ADD** ❑**DELETE** ❑ **CHANGE**

COVERAGE	PLAN NAME	COVERAGE LEVEL
MEDICAL INSURANCE		
DENTAL INSURANCE		
HEALTH CARE FSA		SPECIFY PER PAY AMT
DEPENDENT CARE FSA		SPECIFY PER PAY AMT
SUPPLEMENTAL LIFE		

I CERTIFY THAT THE CHANGE(S) REPORTED ABOVE ARE ACCURATE AND TRUE. I UNDERSTAND THAT UPON REQUEST I MAY BE REQUIRED TO PROVIDE SATISFACTORY PROOF OF ACCURACY. IF ANY INFORMATION IS FOUND TO BE FALSE OR MISLEADING, I MAY BE SUBJECT TO DISCIPLINARY ACTION. DISCIPLINARY ACTION MAY INCLUDE LOSS OF THE REQUESTED BENEFIT CHANGE, SUSPENSION AND/OR TERMINATION OF EMPLOYMENT FOR CAUSE.

Signed: ____ Date: ________________________

5/2011