

GROUP CHANGE FORM

Employee's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_  
(Last) (First) (MI)

Employer's Name \_\_\_\_\_

Provide the Effective Date of Change \_\_\_\_/\_\_\_\_/\_\_\_\_ Circle the appropriate change below and complete the appropriate numbered sections below. In order to expedite your change efficiently and accurately, please be sure all applicable information has been completed.

Change	Section	Type	Section	Type	Section
Name	1	Earnings	6	Terminate Employee - All Coverage	11
Address	2	Beneficiary	7	Terminate Dependents	11 & 12
Marital Status	3	Add Coverage	8	Employee Retired	11
Job Location	4	Terminate Specific Coverage	9	Add Dependents	12
Job Title	5	Reinstate Coverage	10	Other _____	

Change Class to : Health Weekly Income Life Dental

1 Name To \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI)  
 2 Address \_\_\_\_\_ (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code)  
 3 Marital Status Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_  
(Check Appropriate Change)  
 4 Job Location \_\_\_\_\_ 5 Job Title \_\_\_\_\_  
 6 Earnings \_\_\_\_\_ Hours Worked Weekly \_\_\_\_\_ Hours Worked Yearly \_\_\_\_\_

7 LIFE BENEFICIARY \_\_\_\_\_ (First Name) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last Name)  
 Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship \_\_\_\_\_ Benefit Amount \$ \_\_\_\_\_

**The amount of Life Insurance in force at any time shall be in accordance with the provisions of the Master Policy.**

This section is to be completed for SPECIFIC changes to coverage only. Circle appropriate type of Coverage Affected.

8 Add Coverage      9 Terminate Specific Coverage      10 Reinstate Coverage  
 Health- Employee Only      Health - Dependent(s) Only      Health - Employee and Dependent(s)      Health - Waive  
 Life - Employee Only      Life - Dependent(s) Only      Life - Employee and Dependent(s)      Life - Waive  
 Dental- Employee Only      Dental - Dependent(s) Only      Dental - Employee and Dependent(s)      Dental - Waive  
 Weekly Income - Employee Only      Weekly Income - Waive

**If waiving coverage, or an employee with dependents electing employee only coverage, read the NOTICE TO LATE ENROLLEES below.**

11 Terminate All Coverage **Note this section must be completed for ALL EMPLOYEE TERMINATIONS AND DEPENDENT TERMINATIONS.**

Circle appropriate termination. Employee Only Coverage      Dependent Only Coverage      Employee and Dependent Coverage

Last Day Worked \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Coverage Terminated \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for Termination of Coverage \_\_\_\_\_

12 Dependent Information

Name	Last	First	MI	Birth Date	Sex	Relationship	Marital Status	Date Married or Divorced
Spouse	_____	_____	_____	____/____/____	_____	_____	_____	____/____/____
Child 1	_____	_____	_____	____/____/____	_____	_____	_____	____/____/____
2	_____	_____	_____	____/____/____	_____	_____	_____	____/____/____
3	_____	_____	_____	____/____/____	_____	_____	_____	____/____/____

Do all dependent children reside in your household? Yes \_\_\_\_\_ No \_\_\_\_\_ What percent of their support is provided? \_\_\_\_\_

**NOTICE TO LATE ENROLLEES:** If you are not covered within 31 days after becoming eligible, you are required to fulfill the following requirements prior to receiving coverage: Provide proof of eligibility, complete an Enrollment Form, provide a Certificate of Creditable Coverage from your prior plan and comply with any other policies outlined in your Group Health Plan Document under Late Enrollees and Special Enrollment.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_