REQUEST FOR EMPLOYEE CHANGE

Employer: _____ **Group#**_____

Employee Name:_____ **SSN#**_____

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	SSN#	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	SSN#	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 Employees Name to:_____

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

_____

_____

_____

Employee Signature:_____ **Date:**_____

Company Representative _____ **Date:**_____

Authorized Signature