REQUEST FOR EMPLOYEE CHANGE

Employee # _____ Department #: _____

Employee Name:_____ Social Security #: _____

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

☐ Add Dependent Coverage for the following (list dependent to be added):

☐ Decrease or Termination Dependent coverage (list dependent(s) to be dropped)

Dependent Name	Social Security #	Sex	Date of Birth	Relationship

I wish to make the following changes to my vision coverage:

☐ Add Dependent Coverage for the following (list dependent to be added):

☐ Decrease or Termination Dependent coverage (list dependent(s) to be dropped)

Dependent Name	Social Security #	Sex	Date of Birth	Relationship

I wish to make the following changes to my life coverage:

☐ Change beneficiary ☐ Increase Amount ☐ Decrease Amount

I wish to cancel coverage:

☐ Health & Dental ☐ Vision ☐ Supplemental Life

Reason _____ Date: _____

Reason for Change Request: (Change in Family Status)

☐ Marriage ☐ Spouse loss of Job ☐ Adoption ☐ Birth ☐ Loss of Medicaid

☐ Divorce ☐ Dependent eligible for employer coverage ☐ Dependent is over age 26

☐ Other _____

Date of Change: _____

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

Employee Signature: _____ Date: _____

Company Representative: _____ Date: _____