BENEFIT CHANGE REQUEST FORM

Employee:_____ **Social Security Number**:_____

Telephone Number:_____

☐ **ADD SPOUSE**

Name:_____ Date of birth:_____
Date of Marriage:_____ Spouse employed Yes ☐ No ☐
Spouse's SS No._____
Employed By:_____ _____
Company Name City, State of Employment
Is your spouse covered or insured under any other medical coverage (**including Medicare and other government** plans)? ☐No ☐ Yes
If Yes, indicate who the carrier is: _____

☐ **ADD CHILDREN**

Full Name (Please Print Clearly	SSN	Date of Birth	Male (M) Female (F)	Age

Are children covered or insured under any other medical coverage **(including Medicare and other government plan)?** ☐No ☐ Yes If **yes**, indicate who is covered under this other coverage, and who the carrier is: _____

Are any of the other dependents listed above in the legal custody of another person?
☐No ☐ Yes If **Yes** (See box below)

Dependent	Person with Legal Custody	Relationship	Address of Custodian

☐ **TYPE OF COVERAGE TO BE ADDED**

☐ Add All Coverage As of : _____

☐Add Medical As of:_____

☐Add Dental As of:_____

☐Add Vision As of:_____

☐ **CHANGE MARITAL STATUS**	FROM: ☐Single ☐ Divorced ☐ Married ☐ Separated ☐Widowed	To: ☐ Married ☐ Divorced ☐Separated ☐ Widowed

☐ **NAME CHANGE**	☐Employee Name ☐Dependent's Name ☐Change Name to:_____

☐ **CHANGE ADDRESS**	New Address: _____

☐ **DELETE COVERAGE**	Delete Spouse Name_____ As of_____ Delete Child(ren) Name_____ As of _____

☐ **TYPE OF COVERAGE TO BE DELETED**	☐Delete All Coverage	As of : _____
	☐Delete Medical	As of:_____
	☐Delete Dental	As of:_____
	☐Delete Vision	As of:_____

I hereby request coverage and authorize that any requested contribution for the coverage to which I may be entitled be deducted from my earnings. I am eligible for coverage and am working at least the number of hours per week required by my Employer. I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief. I have legal proof which I can furnish upon request of my relationship to any person listed as a Dependent(s) above. I understand any misstatements or failure to report may be used as a basis for rescission or cancellation of the coverage for me and my dependent(s), if any.

Employee Signature:_____ Date:_____