Employee Change of Status Record

EMPLOYER	Plan ID Number
Employee (First, Middle, Last)	Social Security Number

☐ Name Change (New Name Shown Above) — Previous Last Name

☐ Address Change	Street	City	State	Zip Code

☐ Change Benefits ☐ Medical ☐ Dental ☐ Vision

☐ Change Coverage — Type: ☐ Employee & Family ☐ Employee & Spouse ☐ Employee Only ☐ Employee & Children ☐ Employee & One Child

☐ Reason for Change ☐ Birth ☐ Death ☐ Marriage ☐ Divorce ☐ Employment Status Change
Date of Marriage_____ Date of Divorce_____

☐ Add Dependent
If adding a spouse, is the spouse employed? ☐ Yes ☐ No
If Yes, does the spouse have other insurance coverage? ☐ Yes ☐ No
If Yes, what is the name, address & phone # of that carrier _____

Coverage Effective Date (MM, DD, YY)

Name (First, Middle Initial, Last)	Date of Birth (MM, DD, YY)	Social Security Number	Relationship*	Sex	Ft. Student* (IRS Dependent)	Disabled* Handicapped	Other Coverage* Medical	Other Coverage* Dental
Spouse				M ☐ F ☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent				M ☐ F ☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent				M ☐ F ☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent				M ☐ F ☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

*If 19 years old or older, add name and address of school attending as full-time student and copy of IRS form claiming dependency
School Name and Address _____
*If dependent other than natural child or disabled / handicapped, attach copies of legal guardianship documents or physician statement
*Other coverage, Name and Address

☐ Drop Dependent — Date Benefits Terminate (MM, DD, YY)

Name	Name	Name

☐ Change in Coverage ☐ Full-Time Employee ☐ Part-Time Employee

☐ TERMINATE EMPLOYEE'S COVERAGE — DATE BENEFITS TERMINATE (MM, DD, YY)

Reason For Termination

☐ Termination of Individual's Employment
☐ Changing to Other Insurance (Proof Required)
☐ Cancellation Due to Non Payment of Premium
☐ Medical Leave of Absence
☐ Converted to Cobra
☐ Other _____

I Hereby Revise My Benefit Election And Salary Reduction Agreement With The Following New Allocation(s)

	From (Per Pay Period)	To (Per Pay Period)
☐ Medical Premium	$	$
☐ Unreimbursed Expenses	$	$
☐ Dependent Care	$	$

I Hereby Agree That My Benefits Will Be Changed As Shown Above

☐ Employee Signature (Required)	Signature in ink	Date (MM, DD, YY)
☐ Employer Signature (Required)	Signature in ink	Date (MM, DD, YY)