MEDICAL/DENTAL/VISION/LIFE INSURANCE CHANGE OF STATUS

Employee Personal Information

Last Name | First Name | Middle Name or Initial | Social Security Number

Change Information

Change: ☐ Address/Phone ☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Flex

Mailing Address | City | State | Zip | Home Phone #

Reason for Change:

☐ Birth: ______/______/______ ☐ Adoption: ______/______/______

☐ Marriage: ______/______/______ ☐ Divorce: ______/______/______

☐ Loss of Cvrg: ______/______/______ ☐ Termination: ______/______/______

☐ Death: ______/______/______ ☐ Other: ______/______/______

Type of Coverage Change

☐ **Add Dependent** ☐ **Drop Dependent**

First MI Last Name	Relationship	Gender	Social Security Number	Date of Birth	Other Insurance
	Spouse				
	Child				
	Child				
	Child				

What Type of New Coverages Do You Want?

☐ ***Medical***
- ☐ Wellness
- ☐ Non-Wellness
  - ☐ Employee Only
  - ☐ Employee & Spouse
  - ☐ Employee & Child(ren)
  - ☐ Employee & Family
  - ☐ Waive

☐ ***Dental***
- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Employee & Family
- ☐ Waive

☐ ***Vision***
- ☐ Base
- ☐ Enhanced
  - ☐ Employee Only
  - ☐ Employee & Spouse
  - ☐ Employee & Child(ren)
  - ☐ Employee & Family
  - ☐ Waive

☐ ***Group Dependent Life (GPA Paid)***

Consent & Signature

I hereby agree that my benefits and payroll deduction will be changed for the coverages as shown above. I understand that my payroll deduction for medical, dental, and/or vision premium(s) will be automatically adjusted for future rate changes.

Employee's Signature | Date

For Benefits Department Use Only

Effective Date: ______/______/______

ADP ______/______/______ Healthgram ______/______/______ NVA ______/______/______

☐ Dpndnts ☐ Med ☐ Dent ☐ Vis ☐ DepL

1/2019