EMPLOYEE CHANGE FORM

Employer's Statement (to be completed by employer)
Group Number(s) Spencer Owen Community Schools Health 00110995, Subgroup 2501 Life 35008 LTD 6827
Name _____ Social Security # _____
Employer Signature _____ Date _____

REQUEST FOR CHANGE: Indicate below the information you wish to change

☐ Name change from: _____ to: _____
Effective Date of Change: _____

☐ Address Change: Street _____ Phone _____
City, State Zip _____ Effective Date of Change _____

Life Insurance
☐ Beneficiary Change to: _____ Date of Birth: _____ Relationship _____
☐ Contingent Beneficiary Change to: _____ Date of Birth: _____ Relationship _____
Effective Date of Change: _____ (List additional beneficiaries on separate sheet of paper)

NOTE: *If you are adding new dependents and are not enrolling them in the Group Health Plan, you must complete this section:*

Name of Person Declining Coverage:	Coverage Provided by ☐ Spouse ☐ Parent ☐ No Coverage
Name of Person Declining Coverage:	Coverage Provided by ☐ Spouse ☐ Parent ☐ No Coverage
Name of Person Declining Coverage:	Coverage Provided by ☐ Spouse ☐ Parent ☐ No Coverage
Name of Person Declining Coverage:	Coverage Provided by ☐ Spouse ☐ Parent ☐ No Coverage

STATUS CHANGES **IMPORTANT: Please indicate reason for the status change:**
☐ Marriage ☐ Divorce ☐ Spouse Deceased ☐ Birth/Adoption ☐ Termination of Employment ☐ No longer a dependent

Date of Status Change: _____

☐ I wish to ***terminate*** the following coverage(s) effective _____.
(Re-enrollment in medical coverage for yourself or a dependent will require documentation of a HIPAA qualifying event.)

Employee: ☐ Medical ☐ Life/AD& D ☐ Supplemental Life ☐ Dependent Life ☐ Spouse Life ☐ LTD
Dependent(s): ☐ Medical Reason for dropping _____

☐ I wish to ***add*** the following coverage(s) effective _____. (All required paperwork must accompany this form).
Enrollment in medical coverage for an employee or dependent will require documentation of a HIPAA qualifying event. Employees must use an Employee Enrollment Form to add health coverage for themselves – dependents may be added on this form.
Employee: ☐ Life/AD& D ☐ Supplemental Life ☐ Dependent Life ☐ Spouse Life ☐ LTD
Dependent(s): ☐ Medical Reason for adding dependent(s) _____

☐ Dependent Status Change
☐ I wish to drop the below listed dependent(s) from my coverage effective _____.
☐ I wish to add the below listed dependent(s) to my coverage effective _____.

First Name	MI	Last Name	Date of Birth	Social Security #	Relationship	Gender
					Spouse	☐ Male ☐ Female
					☐ Son ☐ Daughter ☐ Other	☐ Male ☐ Female
					☐ Son ☐ Daughter ☐ Other	☐ Male ☐ Female

All required paperwork must accompany this form in order to process this change. If the relationship of a dependent is an adopted child or child for whom you have legal custody, you must provide a copy of legal documentation. The information completed above supersedes all prior requests.

Signature _____ **Date** _____

Your coverage is issued by a multiple employer welfare arrangement. The multiple welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State guaranty funds are not available for your multiple employer welfare arrangement

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