



Effective Date for Change: _____

Employee/Member Status Change Form

Employee/Member Name	Social Security#
Employer/Sponsor Name	Unit/Div#

Please make the Following Marked Changes

(Note: Form must be completed in ink or typed, cannot be accepted if completed in pencil)

Generally, once an election is made it cannot be revoked or changed during a Plan Year. However, the Employee may revoke an election and file a new election for the remainder of the Plan year if both the revocation and new election are on account of and consistent with a change of family status. Special enrollment is not available if the previous coverage loss resulted from fraudulent activity or because the person did not pay premiums.

REASON FOR CHANGE	<input type="checkbox"/> Marriage (Date of Marriage) _____ <input type="checkbox"/> Legal Separation _____ <input type="checkbox"/> Divorce (Date) _____ <input type="checkbox"/> Death _____ <input type="checkbox"/> Termination of Employment _____ <input type="checkbox"/> Spouse Newly Eligible or Ineligible for coverage through their employer _____ <input type="checkbox"/> Birth/Newborn (Date) _____ <input type="checkbox"/> Adoption (Date) _____ <input type="checkbox"/> Reduction in work hours resulting in loss of coverage _____ <input type="checkbox"/> Exhaustion of COBRA or state continuation _____ <input type="checkbox"/> Court Order (Please attach copy) _____ <input type="checkbox"/> Other, Specify _____												
CHANGE OF NAME	From: _____ To: _____												
CHANGE OF COVERAGE	ADD: <input type="checkbox"/> Medical DELETE: <input type="checkbox"/> Medical <input type="checkbox"/> Add Dependents Listed Below <input type="checkbox"/> Remove Dependents Listed Below <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Name</th> <th style="text-align: left; border-bottom: 1px solid black;">Relationship</th> <th style="text-align: left; border-bottom: 1px solid black;">Birthdate</th> <th style="text-align: left; border-bottom: 1px solid black;">SS#</th> </tr> </thead> <tbody> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> </tbody> </table> (*If stepchild, does he/she reside with employee at least six months per year? _____) • If application date is more than 30 days after marriage date or birthdate, evidence of insurability may be required, please include completed Health Questionnaire form with your submission.	Name	Relationship	Birthdate	SS#								
Name	Relationship	Birthdate	SS#										
CHANGE OF ADDRESS	From: _____ To: _____												
ACKNOWLEDGEMENT <small>(Office Use Only)</small> Date: _____ By: _____	All requests for Change in Status must be completed within 30 day of the date of the Status Change. I understand that in no event (other than birth or adoption of a child) will this addition or termination be effective prior to per stated plan document. Signature of Insured: _____ Date: _____ Signature of Administrator : _____ Date: _____												