

# Insurance Change Form

*(To be used for a qualifying event)*

**SECTION 1 - EMPLOYEE INFORMATION (Please complete in full and print clearly.)**

Employee Last Name	First MI	Social Security #	
Street Address		Home Phone Number (     )     -	
City	State     Zip Code	Date of Birth / /	Employee Number

**SECTION 2 - PLAN(S) AFFECTED BY CHANGE**

Medical only    
  Dental only    
  Medical and Dental

**SECTION 3 - REASON FOR CHANGE**

Birth or Adoption (Attach a copy of Birth Certificate or Adoption Papers)  
 Marriage (Attach a copy of Marriage Certificate)  
 Divorce (Supporting documentation required; contact HR.)  
 Loss of Group Coverage (COBRA Continuation)  
 Change in hours or FTE from \_\_\_\_\_ to \_\_\_\_\_  
 Other: \_\_\_\_\_

**SECTION 4 - DEPENDENT INFORMATION**

Add	Drop	Relationship to Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different from Employee's)	Gender		Date of Birth Month/Day/Year	Social Security #
				M	F		
				M	F		
				M	F		
				M	F		
				M	F		
				M	F		

**SECTION 5 - EMPLOYEE SIGNATURE**

**I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OF COVERAGE.**

\_\_\_\_\_  
 EMPLOYEE SIGNATURE

\_\_\_\_\_  
 DATE SIGNED

**For HR use only**

Date Processed/Initials: \_\_\_\_\_    
 Effective Date: \_\_\_\_\_