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STATUS CHANGE FORM

INSTRUCTIONS: — Please indicate ONLY the change(s) you are reporting at this time. This Change Form Request will facilitate the change(s) and A NEW APPLICATION IS NOT NECESSARY. The change will not be valid unless signed and dated by the employee (except terminations).

EMPLOYEE INFORMATION

Name: _____ (Last) _____ (First) Social Security Number: _____

SECTION I: GENERAL

a) Name Change: To: _____ (Last) _____ (First) Effective Date: _____

b) Address Change: To: _____ (Street Name) _____ (Number) Effective Date: _____

_____ (City) _____ (State) _____ (Zip Code)

c) Marital Status Change:
☐ Married; Date _____ ☐ Divorced; Date _____ ☐ Legally Separated; Date _____

d) Job Title or Position Change: To: _____ Date: _____

e) Termination of Employment; Date: _____ Reason: _____ (i.e., fired, voluntary termination, lay-off, death, etc.)

SECTION II: DEPENDENT STATUS CHANGE

Please check appropriate boxes and complete corresponding dependent information. Incomplete information will delay approval.

DEPENDENT INFORMATION:

☐ Add ☐ Delete	☐ Add ☐ Delete	☐ Add ☐ Delete
Name _____	Name _____	Name _____
Birthdate _____	Birthdate _____	Birthdate _____
Reason (see below)* _____	Reason (see below)* _____	Reason (see below)* _____
Effective Date _____	Effective Date _____	Effective Date _____

*Please insert the corresponding number as it applies to this change: (1) Marriage (2) Divorce (3) Employment (4) Continue Education (5) Death (6) Cancellation of employer provided insurance plan (7) Other (Please explain)

*If adding spouse and/or dependent, submit Social Security # _____

a) Requested change applies to: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription Drug ☐ Life Insurance ☐ A.D. & D. Insurance ☐ Dependent Life ☐ S.T.D. ☐ L.T.D.

b) Is there any other Group Insurance in force? ☐ Yes ☐ No
(If the answer is YES, a Coordination of Benefits Questionnaire will be forwarded for completion.)

SECTION III: IMPORTANT — APPLIES TO LIFE INSURANCE AMOUNTS

I wish to change my beneficiary designation as recorded with the Insurance Company. ☐ Yes ☐ No
(If the answer is YES, Please Enclose an updated Enrollment Form.)

SECTION IV: ELIGIBLE FOR MEDICARE

My dependent, _____ (Full Name), is eligible for Medicare Plans A and B, prior to the attainment of age 65.

Medicare coverage is effective as of _____ (Month) _____ (Day) _____ (Year).

AUTHORIZATION: I understand that I am authorizing Automated Benefit Services, Inc. to revise my Group coverage record(s) in accordance with the Change Request Form designation. Further, the effective date of the request(s) will be determined by my eligibility and underwriting guidelines of the plan

Date _____ Signature of Employee _____

Name of Employer _____

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