



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;">Birth Date</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> <p>(*If stepchild, does he/she reside with employee at least six months per year? _____)</p> <p>• If application date is more than 30 days after marriage date or birth date, evidence of insurability may be required, please include completed Health Questionnaire form with your submission.</p>	Name	Relationship	Birth Date	SS#								
Name	Relationship	Birth Date	SS#										
CHANGE OF ADDRESS	From: _____ To: _____												
ACKNOWLEDGEMENT <small>(Office Use Only)</small> Date: _____  By: _____	<p>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.</p> <p>Signature of Insured: _____ Date: _____</p> <p>Signature of Administrator: _____ Date: _____</p>												