Benefit Coverage Change Form

Only certain qualifying events permit an employee to change their insurance coverage outside of the open enrollment period.

Employee Information

_____ _____ _____
Last Name First Name MI

_____ _____
Address

____/____/____(____)_____(____)_____(____)_____
Date of Birth Home Phone Work Phone Cell Phone

Adding an employee/dependent/spouse to coverage	**Removing** an employee/dependent/spouse from coverage
☐ Birth or Adoption	☐ Dependent ineligibility (turning 26)
☐ Additional Dependent (through marriage)	☐ Death of employee/spouse/dependent
☐ Involuntary loss of other coverage	☐ Divorce/Legal Separation
☐ Marriage	☐ Receiving coverage elsewhere
☐ Additional Dependent (under 26)	☐ Termination of employment
☐ Spouse, loss of coverage	

Effective change date _____ Check all that apply: UHC ___ DENTAL___ VISION ___

Employee/Spouse/Dependent to be added/removed (circle one):

Name:_____ Date of Birth_____

SSN:_____

Relationship to Employee (you):_____

I certify that the above information is true and that I may be required to furnish documentation to support the change in status. I further understand that this change will affect the amount of the payroll deductions associated with the change.

Employee Signature: _____

Date: _____

Admin Use Only
Date received by Human Resources: _____
Date received by Payroll: _____
Date coverage added/terminated: _____