STATUS CHANGE FORM

To be completed by Employee

Employee ID #: ____________________

Employee Name: ____________________

Date of Birth: ____________________
Month Day Year

ACTION TO BE TAKEN

☐ ADD DEPENDENT

Name First, Middle initial, Last name	Relationship Spouse	Son	Dtr	Other	Date of birth Month/ Day/Year
	☐	☐	☐	☐	/ /
	☐	☐	☐	☐	/ /
	☐	☐	☐	☐	/ /

☐ TERMINATE DEPENDENT

Name First, Middle initial, Last name	Relationship Spouse	Son	Dtr	Other	Date of birth Month/ Day/Year
	☐	☐	☐	☐	/ /
	☐	☐	☐	☐	/ /
	☐	☐	☐	☐	/ /

☐ TERMINATE COVERAGE

☐ All coverage

☐ BENEFICIARY CHANGE Date changed: ____________________

FROM: Name____________________ **TO:** new Beneficiary name: ____________________

☐ NAME OR EMPLOYER CHANGE : ____________________

☐ ADDRESS CHANGE : ____________________

☐ **PLAN CHANGE FROM:** ____________________ TO: ____________________

Employee signature: ____________________ Date: ____________________
Month Day Year

To be completed by Employer

Employer Name: ____________________ **Signature:** ____________________

Group Number: ____________________ **Effective date of action:** ____________________
Month Day Year