EXCEL BENEFIT CHANGE **REQUEST FORM**

Instructions

- This form is used to change various items on your benefits coverage.
- Complete the contact information section to the right.
- Fill in ONLY the areas you are requesting to be changed.
- Place your signature on the second page of this form.
- Return completed form to HR.

CONTACT INFORMATION *(Required)*

EMPLOYER ______ GROUP # ______

FIRST NAME ______ M.I. ______ LAST NAME ______

SSN ______ EMAIL ______

WORK PHONE ______ HOME PHONE ______

ADD / DROP DEPENDENTS

To add or drop additional dependents, attach a separate sheet with your signature containing the below information.

FIRST NAME ______ M.I. ______ LAST NAME ______ SSN ______ DOB ______

DATE OF CHANGE ______ RELATIONSHIP TO YOU ______ ACTION ☐ ADD ☐ DROP

FIRST NAME ______ M.I. ______ LAST NAME ______ SSN ______ DOB ______

DATE OF CHANGE ______ RELATIONSHIP TO YOU ______ ACTION ☐ ADD ☐ DROP

FIRST NAME ______ M.I. ______ LAST NAME ______ SSN ______ DOB ______

DATE OF CHANGE ______ RELATIONSHIP TO YOU ______ ACTION ☐ ADD ☐ DROP

FIRST NAME ______ M.I. ______ LAST NAME ______ SSN ______ DOB ______

DATE OF CHANGE ______ RELATIONSHIP TO YOU ______ ACTION ☐ ADD ☐ DROP

If dropping coverage: REASON FOR DROPPING DEPENDENT COVERAGE ______

If adding dependent coverage:

DO ANY DEPENDENTS LISTED ABOVE RESIDE WITH THE EMPLOYEE ON A PERMANENT BASIS? ☐ YES ☐ NO

IF NO, PROVIDE DEPENDENT'S NAME AND ADDRESS ______

ARE THERE ANY DEPENDENTS LISTED WHO ARE DISABLED OR HANDICAPPED? ☐ YES ☐ NO

IF YES, PROVIDE DEPENDENT'S NAME AND NATURE OF DISABILITY ______

ARE ANY DEPENDENTS LISTED ELIGIBLE FOR OR RECEIVING MEDICARE? ☐ YES ☐ NO

IF YES, PROVIDE DETAILS ______

ARE ANY DEPENDENTS LISTED ELIGIBLE FOR ANY OTHER GROUP COVERAGE? ☐ YES ☐ NO

IF YES, PROVIDE DETAILS ______

BENEFIT CHANGE **REQUEST FORM**

TERMINATION OF EMPLOYMENT

LAST DAY WORKED ______ WAS THE TERMINATION: ☐ VOLUNTARY ☐ INVOLUNTARY

CHANGE LOCATIONS

FROM ______ TO ______ **DATE OF CHANGE** ______

CHANGE ADDRESS

RESIDENTIAL ADDRESS ______

APARTMENT/UNIT # ______ CITY ______ STATE ______ ZIP CODE ______

CHANGE NAME

CHANGE: ☐ FIRST NAME ☐ LAST NAME

CURRENT FIRST AND LAST NAME ______

NEW FIRST AND LAST NAME ______

EMPLOYEE AND EMPLOYER SIGNATURES *(Required)*

EMPLOYEE SIGNATURE	DATE	EMPLOYER/HR SIGNATURE	DATE