

Addition / Termination / Change Form

Name of Company: _____

Name of Employee: _____

Address(if changed): _____

City: _____ State: _____ Zip: _____

Add Spouse/Partner Effective _____ Reason For Addition Newly Married _____
Date Date of Marriage
Name: _____ Open Enrollment
 Other (Please Specify) _____
Date of Birth _____ Social Security # _____ Sex _____

Add Dependent To Plan Effective (Date) _____ Reason For Addition Newborn
 Open Enrollment
Name: _____ Other (Please Specify) _____
Date of Birth _____ Social Security # _____ Sex _____

Terminate The Following Individuals: Employee Spouse/Partner Only Dependent(s) Only
 Spouse and Dependent(s) Only Family
Last Date of Coverage _____ Reason for Termination: Left Employer
 Switched to Another Plan
 Discontinue Cobra
 Other (Please Specify) _____

Change Effective Date of Change _____
Name of Member for Whom Change is Being Made _____
 New Name _____
 Address _____
 Telephone (Work) _____

Change to Cobra: Employee Employee And Spouse Employee and Dependent(s)
 Spouse Only Dependent(s) Only Spouse and Dependent(s) Only
 Family Partner Only
Qualifying Event _____ Date of Qualifying Event _____
Date of Cobra Effective _____

Other _____ Reason _____

Signature of Employee Date

Employer must complete

Submitted by Signature Date