

Effective Date  Office Use Only

Location  Office Use Only

Group Number  Office Use Only

# Memorial Health System

## Health, Vision and Dental Insurance Changes

### ADD/CHANGE FORM

Federal regulations limit when you can cancel or change your insurances(s) to whenever you and/or your spouse experience a "change in status". These events are considered "changes in status": marital status, number of dependents, employment status, work schedule, or health coverage elsewhere. **You must submit this form within 31 days of a "change of status".**

INSTRUCTIONS: Complete all applicable information below. Please print. Sign the form & return to Human Resources.

**1) PERSONAL INFORMATION**

CURRENT LAST NAME	FIRST	BADGE NO.	STREET ADDRESS
SOCIAL SECURITY NO.	CITY	STATE	ZIP CODE
DATE OF BIRTH	SOCIAL SECURITY NO		PHONE NO

**2) STATUS CHANGE: Attach documentation supporting your status change (ie: Marriage license, death certificate, birth record, divorce decree, etc.).**

MY "Status Change" is: \_\_\_\_\_

**3) CANCEL COVERAGE: Initial the box(es) of all insurance types you would like to cancel**

 Cancel Health Coverage  
 Cancel Dental Coverage

 Cancel Vision Coverage  
 Cancel Flexible Spending Account(s)

**4) CHANGE IN COVERAGE:**

	MEDICAL				VISION	DENTAL			AETNA	
	PLAN A	PLAN B	PLAN C	PLAN D	STANDARD	BASIC	PREMIUM	PLAN 1	PLAN 2	
SINGLE										
SINGLE +1										
FAMILY										

**5) FLEXIBLE SPENDING ACCOUNT:**

MEDICAL: Annual Election: \$ \_\_\_\_\_

DEPENDENT: Annual Election: \$ \_\_\_\_\_

**6) CHANGE IN ELIGIBLE DEPENDENTS:**

List only *new* dependents below

Spouse	Date of Birth	SSN	Marriage Date
Dependent	Date of Birth	SSN	Relationship
Dependent	Date of Birth	SSN	Relationship
Dependent	Date of Birth	SSN	Relationship

List only dependents to be *dropped* below

Name	Reason for dropping coverage	Relationship
Name	Reason for dropping coverage	Relationship

**7) DEDUCTION INFORMATION:**

By my signature below, I certify that I and/or my spouse have experienced a "change of status" in accordance with Federal regulations as explained in the Group Benefit Plan document and that I have submitted this form **within 31 days of that event**. Also, I authorize Memorial Health System, Inc. to make whatever adjustments necessary in my before tax payroll deductions for the above elections.

**Team Member Signature** \_\_\_\_\_ **Date** \_\_\_\_\_