**Health Care Benefits Change Form**

**Remove Dependents**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|       |       |  |       |  |       |
| Last Name (Please Print) | First Name |  | Employee Number |  | Department |
|       |  |       |       |       |  |       |
| Home Address - Street |  | City | State | Zip |  | Daytime Phone number |

**Remove Spouse/Domestic Partner**

**Remove from**  [ ]  Medical [ ]  Dental [ ]  VisionEffective Date:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Last Name | First Name | MI |  |  |  |  |  |
| *Reason* |  |  |  |  |  |
| [ ]  Divorce  | Date Final  |       | [ ]  Death of spouse/domestic partner |
| [ ]  Legal Separation/Annulment  | Date Recorded  |       | [ ]  Medical coverage available from other employer |
| [ ]  Termination of domestic partnership | [ ]  Other  |       |  |
| ***Please attach*** *Termination of Marriage/Domestic Partnership form*  |  |
|  |  |  |
| New Mailing Address – Street City State Zip |
|  |  |

**Delete Dependent Child(ren)**

**Delete from**  [ ]  Medical [ ]  Dental [ ]  VisionEffective Date:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Last Name | First Name | MI |  |  |  |  |
| *Reason* |  |  |  |  |  |
| [ ]  Divorce  | [ ]  Termination of domestic partnership | [ ]  Dependent reached age limit |  |
| [ ]  Legal Separation/Annulment  | [ ]  Death of dependent | [ ]  Other medical coverage available |  |
| ***Please attach*** *Termination of Marriage/Domestic Partnership form*  | [ ]  Other |       |  |
|  |  |  |
| New Mailing Address – Street City State Zip |
|  |  |

**Delete from**  [ ]  Medical [ ]  Dental [ ]  VisionEffective Date:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Last Name | First Name | MI |  |  |  |  |
| *Reason* |  |  |  |  |  |
| [ ]  Divorce  | [ ]  Termination of domestic partnership | [ ]  Dependent reached age limit |  |
| [ ]  Legal Separation/Annulment  | [ ]  Death of dependent | [ ]  Other medical coverage available |  |
| ***Please attach*** *Termination of Marriage/Domestic Partnership form*  | [ ]  Other |       |  |
|  |  |  |
| New Mailing Address – Street City State Zip |
|  |  |

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

Employee’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department HR Rep \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Entered into HRIS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 COBRA Notification sent - Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Revised 2/25/2020*