**Health Care Benefits Change Form**

**Add Dependents\***

**Change IRS Tax Status of Dependent(s)**

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

**Add Spouse/Domestic Partner**

**Add to** [ ]  Medical [ ]  Dental [ ]  VisionEffective Date:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Last Name | First Name | MI |  | Social Security Number |  | Date of birth |  |
| *Relationship* |  |  |  |  |  |  |  |  |
| [ ]  Spouse  |  | [ ]  Male  |  | my IRS tax dependent |  |
| [ ]  Domestic Partner  |  | [ ]  Female |  | [ ]  Yes [ ]  No  |  |
| *Reason* |  |  |  |  |  |
| [ ]  New spouse/domestic partner (attach Affidavit of Marriage/Domestic Partnership) | [ ]  COBRA Coverage ended |
| [ ]  Lost eligibility for other medical coverage (attach proof of other coverage) | [ ]  Change in IRS Tax Status **[ ]  Yes** Now my IRS tax dependent. [ ]  **No** |

**Add Dependent Child(ren) Add to** **[ ]** Medical [ ]  Dental [ ]  VisionEffective Date:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Last Name | First Name | MI |  | Social Security Number |  | Date of birth |  |
| *Relationship* |  |  |  |  |  |
| **Employee’s Dependent** | **OR** | **Partner’s Dependent** | **OR** | **Other** (Step-child or Legal Guardian) |  |
| [ ]  Son [ ]  Daughter  |  | [ ]  Son [ ]  Daughter  |  | [ ] Male [ ]  Female |  |
| *Reason* |  |
| [ ]  Birth/Adoption | [ ]  Court order/legal guardianship. | [ ]  Lost other coverage (attach proof of coverage) |
| [ ]  COBRA Coverage ended | [ ]  Marriage/domestic partnership | [ ]  Other  |  |
|  |  |  |
|  |
| Mailing Address – Street City State Zip |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Last Name | First Name | MI |  | Social Security Number |  | Date of birth |  |
| *Relationship* |  |  |  |  |  |
| **Employee’s Dependent** | **OR** | **Partner’s Dependent** | **OR** | **Other** (Step-child or Legal Guardian) |  |
| [ ]  Son [ ]  Daughter  |  | [ ]  Son [ ]  Daughter  |  | [ ] Male [ ]  Female |  |
| *Reason* |  |
| [ ]  Birth/Adoption | [ ]  Court order/legal guardianship. | [ ]  Lost other coverage (attach proof of coverage) |
| [ ]  COBRA Coverage ended | [ ]  Marriage/domestic partnership | [ ]  Other  |       |
|  |
| Mailing Address – Street City State Zip |

**Dependent Eligibility Information:** If you have listed a dependent child over the age of 18 years, please answer the questions below about your dependent:

1. Incapacitated or Disabled? [ ]  Yes [ ]  No 2. Working full time and have access to health insurance? [ ] Yes [ ]  No

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. *Your dependents’ enrollment is subject to verifying their eligibility.*

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

Benefits Rep \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Entered into HRIS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Revised 2/25/2020*