BENEFIT STATUS CHANGE FORM

Name	Work Location
Employee ID #	Contact Number to be reached
Address	City/State/Zip
Date of Event	

CHANGE OF STATUS (Check which applies and attach applicable proof or documentation)

- ❑ Marriage
- ❑ Birth or adoption
- ❑ Employee gains or loses coverage
- ❑ Spouse gains or loses coverage
- ❑ Dependent gains or loses coverage
- ❑ Legal separation
- ❑ Increase or decrease in hours
- ❑ Court order to add/drop coverage for a dependent
- ❑ Civil Union
- ❑ Start or return of FMLA
- ❑ Divorce
- ❑ Start or return of unpaid leave of absence
- ❑ Gain or loss of Student Status
- ❑ Gain or loss of outside medical coverage
- ❑ Gain or loss of other dependent's eligibility
- ❑ Death of spouse or dependent
- ❑ Change in cost
- ❑ Change in dependent care provider

REQUESTED CHANGE TO COVERAGE: ❑ ADD ❑ REMOVE

Name	Social Security # (REQUIRED)	Relationship	Gender	DOB	Disabled Dependent Y/N	F/T Student* Y/N

*Full-Time student status over age 19 required for Dental enrollment

If enrolling a spouse to medical: Is your spouse employed? _____ If yes, does your spouse have coverage available? _____ Employer Name/Address _____If coverage is offered through your spouse's employer you will be charged a $75 per pay surcharge.

Have you or a spouse being added to medical coverage used any tobacco products within the last 60 days of the coverage requested date? Yes or No. If yes, please check box: □ You □ Spouse. A $35 per pay per smoker surcharge will be added to coverage unless you enroll in the smoking cessation program within 31 days of your coverage effective date. Contact HR for enrollment details.

CHANGE OF LIFE INSURANCE BENEFICIARY DESIGNATION –Use additional sheet if necessary for more beneficiaries

Please provide full name and relationship. If designating more than one beneficiary, please indicate BY PERCENTAGE how you want your benefit divided.

_____

Name SSN# Relationship Date of Birth Percentage % Primary **OR** Contingent

_____

Name SSN# Relationship Date of Birth Percentage % Primary **OR** Contingent

❑**ADD** ❑**DELETE** ❑ **CHANGE**

COVERAGE	CHECK BENEFIT TO BE CHANGED	CIRCLE ELECTION OR ENTER AMOUNT
MEDICAL COVERAGE		CAPITAL CHOICE **OR** CAPITAL SELECT
DENTAL COVERAGE		DELTA PREMIER **OR** DELTA PPO
VISION COVERAGE		
HEALTH CARE FSA		SPECIFY PER PAY AMT
DEPENDENT CARE FSA		SPECIFY PER PAY AMT
SUPPLEMENTAL LIFE		
LEGAL PLAN		

I CERTIFY THAT THE CHANGE(S) REPORTED ABOVE ARE ACCURATE AND TRUE. I UNDERSTAND THAT UPON REQUEST I MAY BE REQUIRED TO PROVIDE SATISFACTORY PROOF OF ACCURACY. IF ANY INFORMATION IS FOUND TO BE FALSE OR MISLEADING, I MAY BE SUBJECT TO DISCIPLINARY ACTION. DISCIPLINARY ACTION MAY INCLUDE LOSS OF THE REQUESTED BENEFIT CHANGE, SUSPENSION AND/OR TERMINATION OF EMPLOYMENT FOR CAUSE.

Signed: _____ Date: _____Eff. 1/2018