

CHANGE / UPDATE FORM

ORIGINAL QUALIFIED BENEFICIARY		
LAST NAME		FIRST NAME
STREET		
CITY	STATE	ZIP
PHONE		SSN
GROUP NAME		
DATE OF STATUS CHANGE		
TYPE OF STATUS CHANGE/REASON FOR CHANGE <input type="checkbox"/> Name Change Only <input type="checkbox"/> New Address <input type="checkbox"/> Adding Dependent _____ <input type="checkbox"/> Deleting Dependent _____ <input type="checkbox"/> Changing Carriers Due to Moving Out of Service Area <input type="checkbox"/> Adding Benefit Due to Status Change/Open Enrollment _____ <input type="checkbox"/> Terminating coverage (list benefit and reason for termination) _____		
New Qualified Beneficiary Information (in the instance of new marriage, birth or adoption, loss of coverage)		
LAST NAME		FIRST NAME
DOB	If you are adding a newborn, please contact BenefitHelp Solutions when you receive your dependent's SSN. SSN	GENDER: M F
New Carrier Information (if moving out of service area or terminating coverage due to new carrier)		
PREVIOUS MEDICAL		PREVIOUS DENTAL
NEW MEDICAL		NEW DENTAL
SIGNATURE		DATE

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