**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:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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|  | | |  | | |  | |  |  | | | | | |  |  | | |  |
| 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:

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|  | | |  | | | | | |  | | | |  |  | | | | | | |  |  | |  |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | |

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|  | | |  | | | | | |  | | | |  |  | | | | | | |  |  | |  |
| 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*