

The Employee Benefit Service Center

Benefit Change of Status Form

Group Number	Group Name	Effective Date of Change

For The EBSC Use

Instructions: Please complete effective date of change, Section 1, and corresponding sections.

Section 1

Social Security #	First Name	Middle	Last Name

Section 2---New Name

Social Security #	First Name	Middle	Last Name

Section 3---New Address

Street Address	City	State	Zip Code	Home Phone Number

Section 4---Enrollment Status

Present Information		Revised Information	
<input type="checkbox"/> Active	<input type="checkbox"/> Full Time	<input type="checkbox"/> Terminated	<input type="checkbox"/> Full Time
<input type="checkbox"/> Cobra	<input type="checkbox"/> Part-Time	<input type="checkbox"/> Retired	<input type="checkbox"/> Part Time
<input type="checkbox"/> Retired	<input type="checkbox"/> Termed	<input type="checkbox"/> Deceased	<input type="checkbox"/> Cobra
<input type="checkbox"/> Location _____		<input type="checkbox"/> Location _____	Date

Section 5---Marital Status

Present Information		Revised Information	
<input type="checkbox"/> Single	<input type="checkbox"/> Separated	<input type="checkbox"/> Single	<input type="checkbox"/> Separated
<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
<input type="checkbox"/> Widowed		<input type="checkbox"/> Widowed	Date

Section 6---Medical/Dental/Vision Coverage

Present Information		Revised Information	
<input type="checkbox"/> Single	<input type="checkbox"/> Medical	<input type="checkbox"/> Single	<input type="checkbox"/> Medical
<input type="checkbox"/> Enrollee + Child	<input type="checkbox"/> Dental	<input type="checkbox"/> Enrollee + Child	<input type="checkbox"/> Dental
<input type="checkbox"/> Enrollee + Spouse		<input type="checkbox"/> Enrollee + Spouse	Date
<input type="checkbox"/> Family		<input type="checkbox"/> Family	

Section 7---Life Benefit

Present Information		Revised Information	
<input type="checkbox"/> Salary _____		<input type="checkbox"/> Salary _____	
<input type="checkbox"/> Short Term Disability		<input type="checkbox"/> Short Term Disability	
<input type="checkbox"/> Long Term Disability		<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> None
<input type="checkbox"/> Voluntary Life _____		<input type="checkbox"/> Voluntary Life _____	Date
<input type="checkbox"/> None			

Life Insurance: Primary and Secondary designation

Name:	First	Last	MI	Relationship	D/O/B
				Primary	
				Secondary	

Section 8---Dependent Changes

First Name	MI	Last Name	Social Security #	Relationship	Add / Drop	Sex	D/O/B	Student
								Y N
								Y N
								Y N

Are you or any of your dependents, who are enrolling for coverage, covered by other health insurance? Yes No

If yes please provide name of applicant	Name and address of insurance company
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Please mail completed form to:
 The Employee Benefit Service Ctr.
 P.O. Box 8130
 South Charleston, WV 25303

I hereby certify that all information is true and correct to the best of my knowledge.

Employee Signature Date

I have reviewed this change and certify that all information is true and correct to the best of my knowledge.

Employer Signature or Authorized Personnel Date