HEALTH CARE BENEFITS CHANGE FORM

REMOVE DEPENDENTS

Last Name (Please Print) First Name ______ Employee Number ______ Department ______

Home Address - Street ______ City State Zip ______ Daytime Phone number ______

Delete Spouse/Domestic Partner

Delete from ☐ Medical ☐ Dental ☐ Vision Effective Date:______

Last Name First Name MI ______

Reason

☐ Divorce Date Final ______
☐ Legal Separation/Annulment Date Recorded ______
☐ Termination of domestic partnership
***Please attach** Termination of Marriage/Domestic Partnership form*

☐ Death of spouse/domestic partner
☐ Medical coverage available from other employer
☐ Other ______

New Mailing Address – Street City State Zip ______

Delete Dependent Child(ren)

Delete from ☐ Medical ☐ Dental ☐ Vision Effective Date:______

Last Name First Name MI ______

Reason

☐ Divorce
☐ Legal Separation/Annulment
☐ Termination of domestic partnership
☐ Death of dependent
***Please attach** Termination of Marriage/Domestic Partnership form*

☐ Dependent reached age limit
☐ Other medical coverage available
☐ Other ______

New Mailing Address – Street City State Zip ______

Delete from ☐ Medical ☐ Dental ☐ Vision Effective Date:_____

Last Name First Name MI ______

Reason

☐ Divorce
☐ Legal Separation/Annulment
☐ Termination of domestic partnership
☐ Death of dependent
***Please attach** Termination of Marriage/Domestic Partnership form*

☐ Dependent reached age limit
☐ Other medical coverage available
☐ Other ______

New Mailing Address – Street City State Zip ______

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.

Employee's Signature ______ Date ______

Department HR Rep ______ Date Entered into HRIS ______

❒ COBRA Notification sent - Date ______

Revised February 2011