HEALTH CARE BENEFITS CHANGE FORM

ADD DEPENDENTS

CHANGE IRS TAX STATUS OF DEPENDENT(S)

Last Name (Please Print) First Name | Social Security Number | Employee Number

Home Address - Street | City | State | Zip | Email

Add Spouse/Domestic Partner

Add to ☐ Medical ☐ Dental ☐ Vision Effective Date: _____

Last Name | First Name | MI | Social Security Number | Date of birth

Relationship

☐ Spouse ☐ Domestic Partner ☐ Male ☐ Female My IRS tax dependent ☐ Yes ☐ No

Reason

☐ New spouse/domestic partner (attach Affidavit of Marriage/Domestic Partnership)

☐ Lost eligibility for other medical coverage (attach proof of other coverage)

☐ COBRA Coverage ended

☐ Change in IRS Tax Status ☐ **Yes** Now my IRS tax dependent. ☐ **No**

Add Dependent Child(ren

Add to ☐ Medical ☐ Dental ☐ Vision Effective Date: _____

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 _____

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 _____

Dependent Eligibility Information: If you have listed a dependent child over the age of 26 years, please answer the questions below about your dependent:

1. Incapacitated or Disabled? ☐ 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.

Employee's Signature _____ Date _____

Revised April 2024