Status Change Form

Instructions: Please indicate ONLY the change(s) you are reporting at this time. This Status Change Form will facilitate the change(s) and A NEW APPLICATION IS NOT NECESSARY. **The change will not be valid unless signed and dated by the employee (except terminations).**

Employee Information

Name: Last, First, Initial ______________________ SS No./ID No.______________

Section I General

A) Name Change to:
Last, First, Initial ______________________ Effective Date ____________

B) Address Change to:
Street Name and Number ______________________ Effective Date ____________
City Street Zip ______________________

C) Marital Status Change to:
☐ Married: Date __________ ☐ Divorced: Date __________ ☐ Legally Separated: Date __________

D) Job Title or Position Change to: ______________________ Date: ______________

E) Termination of Employment: Date ______________________
Reason (i.e. fired, voluntary termination, lay-off, death , etc.): ______________________

Section II Dependent Status Change

Please check appropriate boxes and complete corresponding dependent information. Incomplete information will delay approval.

Dependent Information:

	☐ Add ☐ Delete	☐ Add ☐ Delete	☐ Add ☐ Delete
Name			
Social Security Number			
Date of Birth			
Reason (see below)*			
Effective Date			

*Please insert the corresponding number as it applies to this change: (1) Marriage (2) Divorce (3) Employment (4) Continue Education (5) Death (6) Cancellation of employer provided insurance plan (7) Other (Please explain)

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A) Requested change applies to: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription Drug ☐ Life Insurance ☐ A.D. & D. Insurance ☐ Dependent Life ☐ S.T.D. ☐ L.T.D

B) Is there any other Group Insurance in force? ☐ Yes ☐ No
If the answer is YES, please provide name of other insurance carrier ______________________

Section III Important - Applies to Life Insurance Amounts

I wish to change my beneficiary designation as recorded with the Insurance Company ☐ Yes ☐ No

If the answer is YES, please provide beneficiary's name: Last, First, Initial ______________________

Section IV Eligible for medicare

My dependent, (full name) ______________ is eligible for Medicare Plans A and B, prior to the attainment of age 65.

Medicare coverage is effective as of (Month, Day, Year) ______________________

Authorization

I understand that I am authorizing Automated Benefit Services, Inc. to revise my Group coverage record(s) in accordance with the Change Request Form designation. Further, the effective date of the request(s) will be determined by my eligibility and underwriting guidelines of the plan.

Date ______________________ Employee Signature______________________

Name of Employer ______________________ Employer Signature ______________________

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ABS Automated Benefit Services