HEALTH CARE BENEFITS CHANGE FORM

REMOVE DEPENDENTS

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

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

Delete Spouse/Domestic Partner

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

Last Name First Name MI

Reason

☐ Divorce Date Final _____ ☐ Death of spouse/domestic partner

☐ Legal Separation/Annulment Date Recorded _____ ☐ Medical coverage available from other employer

☐ Termination of domestic partnership ☐ Other _____

Please attach *Termination of Marriage/Domestic Partnership form*

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 ☐ Termination of domestic partnership ☐ Dependent reached age limit

☐ Legal Separation/Annulment ☐ Death of dependent ☐ Other medical coverage available

Please attach *Termination of Marriage/Domestic Partnership form* ☐ Other _____

New Mailing Address – Street | City | State | Zip

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

Last Name First Name MI

Reason

☐ Divorce ☐ Termination of domestic partnership ☐ Dependent reached age limit

☐ Legal Separation/Annulment ☐ Death of dependent ☐ Other medical coverage available

Please attach *Termination of Marriage/Domestic Partnership form* ☐ 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 _____

Revised December 2019