HEALTH CARE BENEFITS CHANGE FORM REMOVE DEPENDENTS

Last Name (Please Print) First Name		Social Security Number		Number	Employee Number	
	ity	State	Zip	Email		
Partner						
Dental Vision	1	Effective I	Date:			
First Name	MI					
			Death of spouse/domestic partner			
	ded			erage availab	e from other employer	
	artnership for		er			
	City	Sta	te	Zip		
	1	Effective I)ate:			
Eirst Nama	MI					
First Name	MI	<u> </u>				
Termina	ntion of dome	estic partnershi	р <u>[</u>	•	reached age limit	
Termina	ntion of dome f dependent	•	p [•	reached age limit cal coverage available	
Termina	ntion of dome f dependent	•	p [•	•	
☐ Termina ment ☐ Death of Marriage/Domestic Pa	ntion of dome f dependent	•		Other medic	•	
☐ Termina ment ☐ Death of Marriage/Domestic Pa	tion of dome f dependent artnership for City	m	Ee E	Other medic	•	
Termina ment Death of Marriage/Domestic Pa	tion of dome f dependent artnership for City	m Sta	Ee E	Other medic	•	
Termina ment Death of Marriage/Domestic Pa	tion of dome f dependent artnership for City	m Sta	Ee E	Other medic	•	
Termina ment Death of Marriage/Domestic Pa	tion of dome f dependent artnership ford City MI	m Sta Effective I	te Date:	Other medic Other Zip	cal coverage available	
Termina ment Death of Marriage/Domestic Pa	tion of dome f dependent artnership form City MI ation of dome	m Sta	te Date:	Other medical Other Zip	reached age limit	
Termina ment Death of Marriage/Domestic Pa Dental Vision First Name Termina ment Death of	City MI Attion of dome	m Sta Effective I	te Date:	Other medic Other Zip Dependent	cal coverage available	
Termina ment Death of Marriage/Domestic Pa	City MI Attion of dome	m Sta Effective I	te Date:	Other medical Other Zip	reached age limit	
1	Partner Dental Vision First Name Date Final nent Date Record partnership farriage/Domestic Po	Dental Vision First Name MI Date Final nent Date Recorded partnership farriage/Domestic Partnership for	First Name MI Date Final Deat Date Recorded Med partnership Other City State City State Cartner Effective I	First Name MI Date Final Death of sponent Date Recorded Medical coverant partnership Other City State Effective Date: Death of sponent Death of sponent Date Recorded Medical coverant Death of sponent Date Recorded State City State	Partner Dental Vision Effective Date: First Name MI Date Final Death of spouse/domestic ment Date Recorded Medical coverage available partnership Other City State Zip en)	

Revised December 2019