



Employee Health Plan Change Form

Location

Group No.

Employee Last Name

First Name

SS# or Tall Tree ID

Section 1 – Change of Employee Name or Address

Change Name:

Employee Last Name First Name M.I.
From:

Employee Last Name First Name M.I.
To:

Change Address to:

Employee Home Address

City State Zip Code

Section 2 – Change of Plan Option or Drop Coverage

Drop all coverage for me and any covered dependents
Effective _____
State reason: _____

Section 3 – Add Dependent(s)

Dependent(s) are being added (check one):

- As dependents acquired through birth, marriage, or legal adoption. (Attach copy of birth certificate, marriage license, or adoption papers.)
 As late enrollments
 Due to loss of eligibility under another health plan (name, group number, and telephone number of the other plan must be written on the back of this form, or attach copy of other plan's ID card).
 Open Enrollment

Dependent's Last Name	First Name	M.I.	Sex	Relation	Birth Date (MM/DD/YY)	Social Security Number
					/ /	- -
					/ /	- -
					/ /	- -

Section 4 – Drop Dependent(s)

Dependent(s) are being dropped (check one):

- Because the person(s) listed below no longer meet the requirements for being an eligible dependent under the plan, because of age, marriage, or divorce (please explain reason on the back of this form).
 Due to becoming eligible under another health plan (name, group number, and telephone number of the other plan must be written on the back of this form, or attach copy of other plan's ID card).

Dependent's Last Name	First Name	M.I.	Sex	Relation	Birth Date (MM/DD/YY)	Social Security Number
					/ /	- -
					/ /	- -
					/ /	- -

Section 5 – Other Changes

Describe any other requested changes below:

Section 6 – Employee Signature (Must be Signed)

I am requesting the changes documented on this form and authorize any required changes in payroll deductions.
X _____ / /
Employee Signature Date Signed

Office Use Only

Effective Date of Changes by Section #
Section 1 ___/___/___ Section 4 ___/___/___
Section 3 ___/___/___ Section 5 ___/___/___

X _____
Benefits Representative
Date