402 Graham Avenue • PO Box 1128 • Eau Claire, WI 54702-1128 PHONE: (800)236-7789 • (715)832-5535 • FAX: (715)838-8507

Employee Change Form

Group Name	Group Number	COVERAGE (Check all that apply) Medical ☐ Dental ☐ Disability ☐ Life ☐ Flex ☐

Employee's Last Name	First Name	M.I.	Date of Birth	Social Security Number

DEPENDENT INFORMATION

First Name	MI	Last Name	Date of Birth	Relationship	Social Security Number

Please attach separate sheet if more room is needed for dependents.

Are any dependent children over 19? ☐ Yes ☐ No If yes, do they attend school full-time? ☐ Yes ☐ No Where?

OTHER COVERAGE

In addition to this coverage, will anyone named on this application be covered by Medicare or any other insurance plans? ☐ Yes ☐ No

If Yes, please complete the information below. (If Medicare is applicable, please provide a copy of the card.)

Name of Person w/Other Insurance	Effective Date	Name of Other Insurance	Plan Type (Medical, Dental, Single or Family)

CHANGE(S) DESIRED

☐ Change Name To:

☐ Address Change To:

☐ Date of Termination of Coverage:

☐ Date Continuation (COBRA) Elected:

☐ Date Dependents(listed above) Added:

☐ Date of Marriage:

☐ Delete Dependents(listed above) as of:

☐ Location Change: Date:

☐ Plan Type Change: Date:

☐ Date of Temporary Lay Off:

☐ Date Returned to Work from Lay Off:

☐ Date of Retirement:

Date: Signature of Authorized Employer:

Date: Signature of Employee (Optional):