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)

_____

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