CHANGE FORM

Group Name: _____ Group #: _____

Employee Name: _____ SS # _____

Termination Date: _____ Layoff Date: _____

CHANGES IN TYPE OF COVERAGE

☐ Medical ☐ Dental ☐ Vision ☐ Short-Term Disability ☐ Life

Plan Change (From): _____ Plan Change (To): _____

Effective Date: _____

REASON FOR CHANGE

☐ Death ☐ Marriage ☐ Divorce ☐ Reduction in Hours ☐ Birth/Adption ☐ Over Age

☐ Loss of Coverage Date: _____ ☐ Other _____

DEPENDENT CHANGE

☐ Add This/These Dependent(s) ☐ Drop This/These Dependent(s) Date of Change: _____

Dep's Name (Last)	(First, MI)	(SS#)	(Date of Birth)	(Male/Female)
Dep's Name (Last)	(First, MI)	(SS#)	(Date of Birth)	(Male/Female)
Dep's Name (Last)	(First, MI)	(SS#)	(Date of Birth)	(Male/Female)
Dep's Name (Last)	(First, MI)	(SS#)	(Date of Birth)	(Male/Female)
Dep's Name (Last)	(First, MI)	(SS#)	(Date of Birth)	(Male/Female)

If dependent child is an Adopted Child or if Employee is the Legal Guardian of child, please attached a copy of the adoption papers or legal guardianship papers.

CHANGE OF ADDRESS

Street City State Zip Code

CHANGE OF NAME/BENEFICIARY

☐ NAME CHANGE: _____
☐ BENEFICIARY FROM TO

I understand that if a Medical Questionnaire Form is required for any of the changes requested, the change will not become effective until approved by the Underwriting Department. I hereby authorize an increase in my payroll deduction, if any is required, for this change.

The Employee MUST sign below (except for Employee Termination date and Change of Address

Signature: _____ DATE: _____

Automated Group Administration, Inc.

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