CHANGE / UPDATE FORM

ORIGINAL QUALIFIED BENEFICIARY		
LAST NAME	FIRST NAME	
STREET		
CITY	STATE	ZIP
PHONE	SSN	
GROUP NAME		
DATE OF STATUS CHANGE		

TYPE OF STATUS CHANGE/REASON FOR CHANGE

- ☐ **Name Change Only** ____________________
- ☐ **New Address** ____________________
- ☐ **Adding Dependent** ____________________
- ☐ **Deleting Dependent** ____________________
- ☐ **Changing Carriers Due to Moving Out of Service Area**
- ☐ **Adding Benefit Due to Status Change/Open Enrollment**____________________
- ☐ **Terminating coverage (list benefit and reason for termination)**

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New Qualified Beneficiary Information (in the instance of new marriage, birth or adoption, loss of coverage)		
LAST NAME	FIRST NAME	
DOB	If you are adding a newborn, please contact BenefitHelp Solutions when you receive your dependent's SSN. SSN	GENDER: M F

New Carrier Information (if moving out of service area or terminating coverage due to new carrier)	
PREVIOUS MEDICAL	PREVIOUS DENTAL
NEW MEDICAL	NEW DENTAL

Please sign Below:	
SIGNATURE	**DATE**

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