Personal Benefit Election Change

Company Name:			
Employee Name:			
Change Date:			
Change Affects:	☐ Employee	☐ Spouse	☐ Dependent(s)
Benefits Affected:			

REASONS FOR CHANGE REQUEST (CHECK ALL THAT APPLY)

Family Changes	Event Date
☐ Marriage	
☐ Divorce / Legal Separation	
☐ Death of Dependent	
☐ Birth or Adoption	
☐ Court Ordered Dep. Coverage	
☐ Other: Please describe below	

Employment Changes	Event Date
☐ Job Termination	
☐ Job Commencement	
☐ Change to Full Time	
☐ Change to Part Time	
☐ Leave of Absence	
☐ Other: Please describe below	

Benefit Changes	Event Date
☐ Cost Increase	
☐ Benefit Decrease	
☐ Employer Cancellation	
☐ Other: Please describe at right	

Describe Changes Marked "Other" Below:

EMPLOYEE SIGNATURE: **DATE:**

FOR EMPLOYER USE:	
Effective Date:	**Payroll Date:**
Notes:	
Approved by:	Date Reviewed:

FOR TPA USE	
Effective Date (if approved):	
Notes:	
Approved by:	Date Reviewed:

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