



**CHANGE FORM**  
(2011-2012)

<b>ADMINISTRATIVE USE ONLY:</b> Received by School District Clerk: Date ___/___/___ init ____ Entered by MUST: Date ___/___/___ Notes: _____
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School District Name: \_\_\_\_\_ Group Number: \_\_\_\_\_ **Effective Date of This Change:** \_\_\_\_\_ **20** \_\_\_\_\_

**EMPLOYEE INFORMATION (REQUIRED):**

<b>Employee First Name, Middle Initial</b>	<b>Employee Last Name</b>		<b>Social Security Number</b>	
Address	City	State	Zip	Telephone

**Indicate Type of Change Below:**

- NAME – Please indicate YOUR PRIOR name so we can correctly identify you: \_\_\_\_\_  
 ADDRESS CHANGE       PLAN CHANGE W/ SPECIAL ENROLLMENT       ADD DEPENDENT       DROP COVERAGE  
 DROP DEPENDENT       STATUS CHANGED TO RETIRED       ADD COVERAGE       CHANGE OF BENEFICIARY

**CHANGE MY ENROLLMENT AS INDICATED BELOW:**

First Name, Last Name	Gender	Social Security #	Date of Birth	Relationship	Medical		Dental		Vision	
					Add	Drop	Add	Drop	Add	Drop

**CHANGE OF BENEFICIARY:**

Name	Address	Soc. Sec. No.	Relationship	% of Benefit

**REASON FOR ADD/CHANGE (indicate below)**

**DATE OF EVENT**

**REASON FOR DROP (indicate below)**

**DATE OF EVENT**

<b>Newborn</b> (Provide other parent's DOB to determine coordination of benefits) Other Parent's DOB: _____			<b>Divorce or Legal Separation</b> (Provide address for COBRA notice)		
<b>Adoption / Court Order</b> (attach proof)			<b>Ineligible Dependent</b> Reason: _____		
<b>Marriage</b> (date of marriage required)			<b>Waiving Health Benefit</b> (Complete <i>Health Coverage Waiver</i> on the back)		
<b>* Retired:</b> (You must provide Teachers' Retirement or Public Employees' Systems documentation)			<b>Death</b>		
<b>Loss of Other Coverage</b> (You must provide a <i>Certificate of Creditable Coverage</i> )			<b>Other:</b>		

**Plan Change:**

From: \_\_\_\_\_

To: \_\_\_\_\_

Note: Plan Changes only apply to Special Enrollment Events

(Old Plan Name)

(New Plan Name)

**\* RETIREE MUST COMPLETE FOR LIFE INSURANCE:**

YES, I wish to continue my life insurance

NO, I do not wish to continue my life insurance

**REQUIRED! OTHER INSURANCE INFORMATION** — Do you, your spouse or your children have other medical, dental, or vision insurance that you will retain? Please mark YES or NO for you and your covered dependents.

SELF:  YES  NO      CHILDREN (name) \_\_\_\_\_  YES  NO \_\_\_\_\_  YES  NO

SPOUSE:  YES  NO      \_\_\_\_\_  YES  NO \_\_\_\_\_  YES  NO

*If you mark YES to any of the above, First Choice Health will require further documentation from you in the form of a Multiple Coverage Inquiry form. Forms are available online at [mustbenefits.org](http://mustbenefits.org) or from the school office.*

Employee Signature (required) \_\_\_\_\_

Date (required) \_\_\_\_\_

