BENEFITS CHANGE OF STATUS FORM

EMPLOYEE INFORMATION			
First Name:	M.I.	Last Name:	Social Security Number:
Client Company Name:			

EFFECTIVE DATE OF CHANGE: (mm/dd/yyyy)	

NAME CHANGE			
From:	First Name:	M.I.	Last Name:
To:	First Name:	M.I.	Last Name:

ADDRESS CHANGE				
From:	Street / P.O. Box:	City:	State:	Zip:
To:	Street / P O. Box:	City:	State:	Zip:

EMERGENCY CONTACT					
Add ☐	Delete ☐	First Name:	Last Name:	Phone:	Relationship:
Add ☐	Delete ☐	First Name:	Last Name:	Phone:	Relationship:

QUALIFYING EVENT				
Marriage	Divorce	Gain/Loss of Coverage	Newborn/Adoption	Death

EMPLOYEE OR DEPENDENT ADD/DROP (Please refer to qualifying events below*)

Dependent Information

Name *(First Name MI Last Name)*	DOB *(mm/dd/yyyy)*	SS#	Gender *(M/F)*	Relation *(Spouse/ Child)*	ADD[1]				DROP[1]			
					M	D	V	All	M	D	V	All

[1] M = Medical D = Dental V = Vision All = All Elected Coverages

**Other than Open Enrollment, dependents can only be enrolled due to the following: Divorce Decree, Marriage, Newborn/Adoption, and Gain/Loss of Insurance.*

☐ **I would like to update/change my life insurance beneficiary. Please send forms.**

Employee Signature:		Date Signed:	

Upon completion, send via: Email: Benefits@employerflexible.com OR Fax: 281-598-7541