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EVENT CHANGE FORM
Cooper County - Group: #70100

EMPLOYEE INFORMATION

First Name:_____ **MI:**_____ **Last Name:**_____

Social Security Number: _____ **Effective Date of Change(s):**_____

EMPLOYEE COVERAGE

☐**Medical Base Plan** ☐**Medical Buy Up Plan** ☐**Maxi-Care** ☐**Dental** ☐**Vision** ☐**Life** ***(Employer Paid)***

☐**Voluntary Buy-Up Life** ☐**Voluntary LTD**

☐**Addition**

☐Open Enrollment ☐Birth of Child/Adoption*

☐Marriage* ☐Loss of Other Coverage*

☐Return from Leave of Absence or Military Service

☐**Termination** **Termination Date:** _____

☐Involuntarily Terminated ☐Voluntarily Resigned

☐Reduction in hours ☐Retired

☐Entered Military ☐Open Enrollment

☐Other:_____

Does COBRA Continuation Apply? ☐Yes ☐No

DEPENDENT COVERAGE

☐**Medical/Rx** ☐**Maxi-Care** ☐**Dental** ☐**Vision** ☐**Dependent Life** ☐**Voluntary Dependent Buy-Up Life**

☐**Addition**

☐Open Enrollment ☐Birth of Child/Adoption*

☐Marriage* ☐Loss of Other Coverage*

☐QMCSO*

☐Return from Military Service

☐**Termination** **Termination Date:** _____

☐Loss of "Dependent Child" Status ☐Open Enrollment

☐Divorce*

☐Other:_____

Does COBRA Continuation Apply? ☐Yes ☐No

***Requires** attached proof of Qualifying Event for changes to apply (Marriage License, Divorce Decree, Certificate of Creditable Coverage, etc.).

Dep.#	Relation to Employee	First Name, M. I., Last Name (if different)	Gender (M / F)	Social Security Number	Date of Birth	Effective Date
1						
2						
3						
4						

Will you or any dependents be covered by any other Medical/Dental/Vision Insurance in addition to this Plan?: ☐**Yes** ☐ **No**

- If yes, who?: ☐Employee ☐Spouse ☐Child(ren) Please attach a **Certificate of Creditable Coverage** from that insurance company.

EMPLOYEE NAME CHANGE

Previous Name: _____ New Name:_____

BENEFICIARY CHANGE

New Primary Beneficiary:_____ DOB:_____ SSN#_____ Relationship:_____

New Contingent Beneficiary:_____ DOB:_____ SSN#_____ Relationship:_____

OTHER CHANGE/NOTES

_____

_____

_____

Authorized Signature: X_____ **Date Signed:** _____

(PLEASE DO NOT PRINT)