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EVENT CHANGE FORM

Cooper County Government– Group #70100

EMPLOYER INFORMATION

First Name:______________________ **MI:**_______ **Last Name:**___________________________

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

EMPLOYEE COVERAGE

☐ **Base Plan** ☐ **Buy Up Plan** ☐**Maxi-Care**
☐**Dental** ☐**Vision** ☐ **Voluntary Life** ☐ **Voluntary LTD**

☐**Addition**

☐**Open Enrollment** ☐**Birth of Child/Adoption***

☐**Marriage*** ☐**Loss of Other Coverage***

☐**Return from Leave of Absence or Military Service**

☐**Termination** **Date:** _______________

☐**Involuntarily Terminated** ☐**Voluntarily Resigned**

☐**Reduction in hours** ☐**Retired**

☐**Entered Military** ☐**Open Enrollment**

☐**Other:**_______________________________

Does COBRA Continuation Apply? ☐**Yes** ☐**No**

DEPENDENT COVERAGE

☐ **Base Plan** ☐ **Buy Up Plan** ☐**Maxi-Care**
☐**Dental** ☐**Vision** ☐ **Voluntary Life** ☐ **Dependent Life**

☐**Addition**

☐**Open Enrollment** ☐**Birth of Child/Adoption***

☐**Marriage*** ☐**Loss of Other Coverage***

☐**Return from Military Service**

☐**Termination** **n Date:** _______________

☐Loss of "Dependent Child" Status ☐Open Enrollment

☐Divorce*

☐Other:______________________________

***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						

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.

BENEFICIARY CHANGE

Primary Beneficiary:__________________ DOB:________ SSN#_______________ Relationship:________

Contingent Beneficiary:________________ DOB:_______ SSN#________________ Relationship:________

NAME, SALARY, and OTHER CHANGES or NOTES

____

____

Authorized Signature: X_______________________ **Date Signed:** _______________

(PLEASE DO NOT PRINT)