TALL TREE ADMINISTRATORS

Employee Health Plan Change Form

Location

Group No.

Employee Last Name | First Name | SS# or Tall Tree ID

Section 1 – Change of Employee Name or Address

Change Name:

	Employee Last Name	First Name	M.I.
From:			
To:			

Change Address to:

Employee Home Address | City | State | Zip Code

Section 2 – Change of Plan Option or Drop Coverage

☐ Drop all coverage for me and any covered dependents
Effective _____

State reason: _____

Section 3 – Add Dependent(s)

☐ Medical/Vision ☐ Dental

Dependent(s) are being added (check one):

☐ As dependents acquired through birth, marriage, or legal adoption. (Attach copy of marriage license, or adoption papers.)

☐ As late enrollments
☐ Open Enrollment

☐ Due to loss of eligibility under another health plan (name, group number, and telephone number of the other plan must be written on the back of this form, or attach copy of other plan's ID card).

Dependent's Last Name	First Name	M.I.	Sex	Relation	Birth Date (MM/DD/YY)	Social Security Number
					/ /	- -
					/ /	- -
					/ /	- -

Section 4 – Drop Dependent(s)

Dependent(s) are being dropped (check one):

☐ Because the person(s) listed below no longer meet the requirements for being an eligible dependent under the plan, because of age, marriage, or divorce (please explain reason on the back of this form).

☐ Due to becoming eligible under another health plan (name, group number, and telephone number of the other plan must be written on the back of this form, or attach copy of other plan's ID card).

Dependent's Last Name	First Name	M.I.	Sex	Relation	Birth Date (MM/DD/YY)	Social Security Number
					/ /	- -
					/ /	- -
					/ /	- -

Section 5 – Other Changes

Describe any other requested changes below:

Section 6 – Employee Signature (Must be Signed)

I am requesting the changes documented on this form and authorize any required changes in payroll deductions.

X _____ / /
Employee Signature **Date Signed**

Office Use Only

Effective Date of Changes by Section #

Section 1 ___/___/___ Section 4 ___/___/___

Section 3 ___/___/___ Section 5 ___/___/___

X _____
Benefits Representative

_____
Date