# Employee Change Form

| Employer/**COMPANY** Name | Effective date of Change: (mmm/dd/yyyy) |
|---|---|
| Employees Last & First Name | ❑ Male ❑ Female / Date of Birth (mmm/dd/yyyy) |

| Policy/Group #: | Division Name: | Cert #: | EMPLOYER ISSUED ID #: (IF APPLICABLE) |
|---|---|---|---|

| **Reason for Change:** | | | |
|---|---|---|---|
| | ❑ Terminate this employee | ❑ Change coverage to single | ❑ Change coverage to family |
| | ❑ Reinstate employee | ❑ Delete a dependent | ❑ Add a new dependent |
| | ❑ Address change | ❑ Employee/Dependent Name change | |
| | ❑ HCSA Maximum change | ❑ Add or Remove Spouse's other insurance provider (COB) | |

| **Address Change:** | |
|---|---|

| **Health Spending Account Maximum Change (HCSA):** | New ANNUAL maximum | | Effective date of Change | |
|---|---|---|---|---|

**Coverage Change:**

Spouse/Dependent Information

| Last & First Name | Date of Birth (mmm/dd/yyyy) | Relationship (spouse, son, daughter, etc.) | Is s/he attending full time post-secondary education? | Type of Change |
|---|---|---|---|---|
| | | | | ❑ Add ❑ Remove |
| | | | | ❑ Add ❑ Remove |
| | | | | ❑ Add ❑ Remove |
| | | | | ❑ Add ❑ Remove |

**Name Change:**

| | | |
|---|---|---|
| Employee | From | To |
| Dependent | From | To |

**Spouse's Coverage Change:**

| Indicate your spouse's coverage with his/her employer | | | | | Policy #: |
|---|---|---|---|---|---|
| Health | ❑ Single | ❑ Family | ❑ Waived | ❑ None | |
| Dental | ❑ Single | ❑ Family | ❑ Waived | ❑ None | Insurance Provider Name: |
| Vision | ❑ Single | ❑ Family | ❑ Waived | ❑ None | |

**Protecting your personal information:** At ProBenefits Inc., we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of ProBenefits or the offices of an organization authorized by ProBenefits. We limit access to personal information to your file to ProBenefits staff or persons authorized by ProBenefits who require it to perform their duties, to persons whom you have granted access, and to persons authorized by law. We use the personal information to determine your eligibility for coverage and to administer the group benefits plan.

| | | |
|---|---|---|
| Name of Employee (PLEASE PRINT) | Signature of Employee | Date |

| | | |
|---|---|---|
| Plan Administrator (PLEASE PRINT) | Signature of Administrator | Date |

ProBenefits Inc.
employer benefit solutions

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