ProBenefits Inc.
employer benefit solutions

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Employee Change Form

Section 1

Employer/**COMPANY** Name		Effective date of Change: (MM/DD/YYYY)
Employees Last & First Name	❑ Male ❑ Female	Date of Birth: (MM/DD/YYYY)

Policy/Group #:	Division Name:	Cert #:

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

Section 2

Address Change:	

Section 3

HCSA Maximum Change:	New ANNUAL maximum		Effective date (MM/DD/YYYY)	

Section 4

Coverage Change:

Spouse/Dependent Information

Last & First Name	Date of Birth (MM/DD/YYYY)	Relationship (spouse, son, daughter, etc.)	If applicable, provide Post-Secondary	Program Start Date & Program End Date	Type of Change
					❑ Add ❑ Remove
					❑ Add ❑ Remove
					❑ Add ❑ Remove
					❑ Add ❑ Remove

Section 5

Name Change:

Employee	From	To
Dependent	From	To

Section 6

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	

Section 7

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.

First & Last Name (PLEASE PRINT)	Signature	Date