STATUS CHANGE FORM

PARTICIPANT'S NAME_____

PARTICIPANT'S SOCIAL SECURITY NUMBER_____

PLEASE MARK YOUR SELECTION BELOW

FAMILY COVERAGE

I HAVE HAD THE FOLLOWING SPECIAL ENROLLMENT EVENT TO ADD MY DEPENDENTS:

( ) Involuntary loss of other group health coverage (see back) -complete the following
Name and address of group health plan_____
Phone number of group health plan_____
Date of loss of coverage_____
Reason for loss of coverage_____

( ) Marriage- please submit a copy of marriage license Date_____

( ) Birth of a child-please submit copy of birth certificate Date_____

( ) Adoption of child- please submit legal documentation Date_____

INDIVIDUAL COVERAGE

( ) I wish to drop Family coverage as of the 1st of, _____(1st day of month).

IMPORTANT NOTICE: IF YOU DROP YOUR DEPENDENT COVERAGE, YOU MAY NOT REINSTATE IT UNLESS YOU HAVE A SPECIAL ENROLLMENT EVENT (i.e. THERE IS NO OPEN ENROLLMENT)

_____ _____
SIGNATURE DATE

INVOLUNTARY loss of other group health coverage can occur when

1) your dependent was covered under a COBRA continuation provision and the coverage under that provision was exhausted;
2) your dependent's coverage under the other group health coverage terminated as a result of loss of eligibility for coverage, including termination of employment or reduction in hours of employment; or
3) the employer contributions towards your dependent's coverage under the other group health coverage terminated