

Personal Information

Employer Name: _____ Date: _____

Employee Name: _____ SSN: _____ Date of Birth: _____

Dependent Information: Name Change Adding Dependent Removing Dependent

Name	SSN	Date of Birth	Relationship	Gender	Effective or Termed	Full-Time Student
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Check if this is a change of contact information

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Change of Status

Before submitting this form, ensure that the change you are requesting is allowable under the Change of Status regulations. You must submit a Change of Status form NO LATER than 30 days from the changing event. Effective date(s) cannot be before the date of the event or the date the form is signed and received by eBenefits Administrators, Inc.

Change Existing Benefit/Election Add New Benefit/Election Terminate Benefit/Election Terminate Employment

Existing Benefit/Election: _____ Deduction Amount Per Pay Period: _____

New Benefit/Election: _____ Deduction Amount Per Pay Period: _____

Change of Status Description: _____

Event Date: _____ Termination Date: _____ Loss of Coverage Date: _____

Employer: Please list the first payroll effective date for new/changed benefit/election or the Last payroll deduction date for terminated benefit/election: _____

I certify that I have had the above change in status and request that the changes in my elections be made as indicated. In no event may the actions be effective before the first pay period beginning after this form is completed and submitted.

Employee Signature: _____ Date: _____

COBRA Clients - Qualifying Event (If Applicable)

Please check the applicable qualifying event: Retirement (Voluntary) Reduction of Hours (Full-Time to Part-Time)

Involuntary Termination of Employment Voluntary Termination of Employment Divorce or Legal Separation

Loss of Dependent Status Entitled to Medicare Benefits Death of Employee

Benefit Plan Name	Termination Date	Coverage Tier	Monthly Premium	COBRA Eligible Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Employer Acceptance of this Change of Status/Qualifying Event

Comments: _____

Employer Signature: _____ Date: _____