MUNICIPAL HEALTH BENEFIT FUND

CHANGE OF STATUS OR CHANGE OF BENEFICIARY APPLICATION

(This form is for making changes to an employee's existing coverage)

Employee SSN	**Name of City/Entity**	**Group Number**	**Effective Date of Change**

Last Name	**First Name**	**MI**	**Date of Birth**	**Sex**

1 ☐ **Addition** of DEPENDENT COVERAGE ☐ SPOUSE ☐ CHILD(REN) **/ /**

(Please list eligible dependents below in DEPENDENT SECTION) **(Date of Marriage)**

2 ☐ Add additional dependents to current family policy (Please list eligible dependents below in DEPENDENT SECTION)

3 ☐ **TERMINATION** OF DEPENDENT COVERAGE ONLY

4 ☐ **TERMINATION** OF SPOUSE ONLY _____ / /

(Name) **(Date of Divorce)**

5 ☐ **TERMINATION** OF DEPENDENT CHILD(REN) ONLY

_____ / /

_____ / /

(List dependents to terminate) **(Date no longer eligible dependent)**

6 ☐ **CHANGE** OF NAME * TO _____

(LAST) **(FIRST)** **(MI)**

***(A copy of documentation showing name has been Legally changes must be submitted for name changes to be processed)**

7 ☐ **CHANGE** OF BENEFICIARY

_____

(Name) **(Relationship)**

_____

(Name) **(Relationship)**

DEPENDENT SECTION BELOW

(Please complete this section Only of you are adding Dependent Coverage or Additional Dependents to your Family coverage)

DEPENDENT Name	Relationship to Member	Sex (M/F)	Date of Birth Mo./Day/Yr	Social Security Number of Dependent	Other Ins Coverage

_____ _____

MEMBER/EMPLOYEE SIGNATURE DATE SIGNED

Employer Representative:

If family coverage/dependents are being added the following documents are included

CERTIFICATE OF ACCEPTANCE OF PLAN PROVISIONS (pg.1 of current year benefit booklet) ☐ YES ☐ NO

MULTIPLE COVERAGE INQUIRY FORM (and any additional documentation required by this form) ☐ YES ☐ NO

MHBF USE ONLY

_____ _____

Signature of Employer Representative Date Signed

PLEASE SEE CURRENT MHBF BOOKLET FOR ADDITIONAL INFORMATION

(rev. 2008)