Unified Group Services

GROUP BENEFITS CHANGE FORM

1. _____Termination
2. _____ Dependent Status
3. _____ Name
4. _____ Address

EMPLOYEE NAME	
EMPLOYEE SOCIAL SECURITY NUMBER	
DATE COMPLETED	SIGNATURE OF EMPLOYEE
EMPLOYER **Delaware County Government**	GROUP NUMBER **2925**

ADDING OR TERMINATING EMPLOYEE BENEFITS

I WISH TO TERMINATE THE BELOW MARKED COVERAGE(S) EFFECTIVE: _____

☐ ALL COVERAGES

REASON FOR CHANGE: _____

CHANGE OF DEPENDENT STATUS

PLEASE DELETE THE DEPENDENT(S) LISTED BELOW FROM MY PLAN EFFECTIVE: _____

DUE TO: ☐ DIVORCE ☐ DEATH ☐ OTHER:_____

PLEASE ADD THE FOLLOWING DEPENDENT(S) LISTED BELOW TO MY COVERAGE EFFECTIVE: _____

DUE TO: ☐ MARRIAGE - DATE _____ ☐ BIRTH ☐ OTHER:_____

FULL NAME OF EACH DEPENDENT FIRST MI LAST	RELATIONSHIP	SOCIAL SEC NUMBER	DATE OF BIRTH MO/DAY/YR

CHANGE IN OTHER INSURANCE INFORMATION

IS SPOUSE ELIGIBLE TO ELECT COVERAGE UNDER HIS/HER EMPLOYER'S PLAN? ☐ YES ☐ NO

Name of Insured Person: _____ Employed By: _____

Social Security #: _____

Covered Dependents: _____

Insurance Company Name/Medicare: _____ Medical Policy #: _____

CHANGE OF NAME

FROM: (First, Middle, Last)	TO: (First, Middle, Last)

CHANGE OF ADDRESS

NEW ADDRESS	OLD ADDRESS