CHANGE REQUEST FORM FOR CURRENTLY ENROLLED SUBSCRIBERS
CBX DENTAL, VISION, CHIROPRACTIC & ACUPUNCTURE, & ESPYR EAP

GENERAL INSTRUCTIONS

Employees use **this form** to update personal information or to add/delete coverage.
Employers use the Employee **Termination Form** to notify us of coverage termination due to a Qualifying Event.
Active Employees use the **Coverage Declination Form** to voluntarily cancel one of more types of coverage.

This Form must be received by the Plan Administrator no later than 30 days after the qualifying event takes place in order to qualify for coverage.
Late submissions will be subject to medical underwriting by the insurance carrier.
* Additions to coverage will become effective on the first day of the month following event (marriage, birth, loss of coverage, other).
* Cancellations of coverage will take effect on the last day of the month after receipt of your request by the plan administrator.
* Please attach a copy of marriage certificate or legal documents as applicable.

Please print in blue or black ink

Reason for Change: ❑ Name ❑ Address ❑ Add/Delete Dependents ❑ QE (Choose reason below and attach proof of Change*.)

Type of Qualifying Event (choose one):
❑ Marriage* ❑ Divorce* ❑ Death ❑ Loss of Coverage* ❑ Birth/Adoption ❑ Other_____

SECTION 1: EMPLOYEE INFORMATION

Date of Event (i.e. date of birth, date moved, married, last day of coverage, etc): / /	**Requested Effective Date:** / /	Effective date will be the 1st of the month following waiting period or event.
Name of Company		
Employee Last Name as Originally Enrolled	Employee First Name	M.I.
Employee Social Security Number	Date of Birth (mm/dd/yyyy)	

SECTION 2: NAME/ADDRESS CHANGE (complete this section only if reporting a name or address change)

NEW Last Name	First Name			M.I.
NEW Physical Address (Physical Address, no PO boxes)	Apt #	City	State	Zip Code
NEW Mailing Address (If Different)	Apt #	City	State	Zip Code

SECTION 3: COVERAGE CHANGE (COMPLETE ONLY IF YOU ARE AN ACTIVE EMPLOYEE WHO WANTS TO ADD OR CANCEL DEPENDENTS)

EXISTING CBX EMPLOYEE IS ADDING **ESPYR** EAP FOR SELF & FAMILY (100% ER PAID): (ER Must offer it)	❑ Yes

DEPENDENT GRID	SPOUSE/ DOMESTIC PARTNER	CHILD #1	CHILD #2	CHILD #3
TYPE OF CHANGE:	❑ ADD ❑ CANCEL	❑ ADD ❑ CANCEL	❑ ADD ❑ CANCEL	❑ ADD ❑ CANCEL
LAST NAME:				
FIRST NAME:				
SOCIAL SECURITY NUMBER:	- -	- -	- -	- -
DATE OF BIRTH:	/ /	/ /	/ /	/ /
GENDER:	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
RELATIONSHIP TO EMPLOYEE:	❑ SP ❑ DP			
DISABLED: [1]		❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
DEPENDENT ENROLLING IN: [2] (Only check plans that are offered)	❑ Dental ❑ Vision ❑ Chiro/Acu	❑ Dental ❑ Vision ❑ Chiro/Acu	❑ Dental ❑ Vision ❑ Chiro/Acu	❑ Dental ❑ Vision ❑ Chiro/Acu

[1] For disabled dependents, please submit an Over Age Dependent Certification or Disabled Dependent Certification in addition to this form.
[2] Dependents may enroll up to age 26 (except on MetLife if married or not a student and not living at home).

SECTION 4: YOUR LEGAL ACKNOWLEDGEMENT: (PLEASE READ, SIGN AND DATE BELOW)

MetLife Dental, Vision Service Plan, Blue View Vision, & Landmark Healthplan Enrollees Employee Statement - I request coverage under my employer's group insurance plan as noted and also verify the accuracy of the employee section. Furthermore, I authorize my employer to deduct from my earnings any payment, if applicable for this coverage.

X

EMPLOYEE SIGNATURE TO ENROLL IN COVERAGE DATE

PRINT NAME