



For Administration/Questions
 Employer Plan Services Inc
 PO Box 2727, Houston, TX 77252
 p. 800.207.9224 f. 713.369.0703

EMPLOYEE Change Request Form

Employer:	Group ID:
Policy Number (List all affected policy numbers):	
Employee's Name:	Social Security Number:

COVERAGE BEING CHANGED

<input type="radio"/> Dental	<input type="radio"/> Vision	<input type="radio"/> Life	<input type="radio"/> STD	<input type="radio"/> LTD
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NAME CHANGE (First-MI-Last)/ADDRESS CHANGE:

From:
To:

TERMINATION

Date Employment Ends:	Date Coverage Ends:	Date Continuation Begins*:
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BENEFICIARY CHANGE

Primary Beneficiary:	Relationship:
Contingent Beneficiary:	Relationship:
NOTE: Contingent Beneficiary will receive benefits only if Primary Beneficiary does not survive you. If more than one Primary or Contingent Beneficiary is designated, please attach a separate sheet of paper with specifics.	

DEPENDENTS TO BE ADDED OR REMOVED**

Check One		Name First/MI/Last	Date of Birth Mo/Day/Yr	Relationship: Spouse or Child	Date of Marriage Mo/Day/Yr	Late Entrant** Mo/Day/Yr
Add	Remove					

CHANGES IN COVERAGE for LIFE & DISABILITY

Effective Date of Change:	Current Salary: \$
<input type="radio"/> 1. Increase Employee coverage to \$	
<input type="radio"/> 2. Add/increase spouse coverage to \$	
<input type="radio"/> 3. Add Dependent Life Coverage \$	
Enrollment form must be attached for items 1-3. Evidence of Insurability may be required.	
Effective Date of Change:	
<input type="radio"/> 1. Reduce Employee coverage to \$	
<input type="radio"/> 2. Reduce spouse coverage to \$	

I hereby request coverage as outlined above under the group plan(s) offered by my employer and authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice and understand that if I have declined any coverage on myself or eligible dependent and wish to enroll at a later date, coverage will be deferred in accordance with the plan provisions. I understand and acknowledge that information concerning coverage's, treatments and services I may receive may be distributed and disclosed to my employer, and I hereby consent to the dissemination and disclosure of all information. I declare all answer true and complete.

Employee Signature	Date	Witness Signature	Date
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* For Dental and Vision Coverage only.
 ** If adding a dependent outside of the eligibility period, please explain the reason:
 For foster or adopted child, show date of placement and any adoption decree.
 NOTE: If dependents are late entrants for Life coverage, each dependent will need to complete an Evidence of Insurability form and submit for review.