

CYPRESS BENEFIT ADMINISTRATORS – CHANGE FORM
Dlorah dba National American University Group # 402

Employee name: _____ DOB: _____ SSN: _____

INSTRUCTIONS:

1. Please Print or type.
2. Complete name, date of birth and social security number above
3. Check the change(s) to be made: Name Address Coverage Beneficiary (life only) other
4. Fill in only the section(s) below that pertain to the change(s) to be made.
5. Attach documentation for changes other than for open enrollment (i.e. marriage, birth certificate, etc)
6. If necessary, complete additional forms to make changes for all appropriate family member(s)

Section 1: REASON FOR CHANGE

- | | |
|---|---|
| <input type="checkbox"/> Marriage: date of marriage | <input type="checkbox"/> Legal Separation: date of separation |
| <input type="checkbox"/> Birth: date of birth | <input type="checkbox"/> Death: date deceases |
| <input type="checkbox"/> Adoption: date of adoption | <input type="checkbox"/> Divorce: date of finalized divorce |
| <input type="checkbox"/> Open Enrollment | <input type="checkbox"/> Other |

Section 2: CHANGE IN COVERAGE (to add coverage) check appropriate box and coverage

Use one line for each change for each individual and each type of coverage

Name (First, MI, Last)	Date of birth	Soc. Sec. No	Relationship	M/F
			blank	Female
Type of coverage: blank	blank	blank	blank	
			employee	Female
Type of coverage: blank	blank	blank	blank	
			employee	Female
Type of coverage: blank	blank	blank	blank	
			employee	Female
Type of coverage: blank	blank	blank	blank	
			employee	Female
Type of coverage: blank	blank	blank	blank	
			employee	Female
Type of coverage: blank	blank	blank	blank	

Indicate TYPE(S) of coverage(s) desired after change(s):

- Single Medical Family Medical Single Dental Family Dental waive medical waive dental

Comments:

Section 3: CHANGE IN NAME OR ADDRESS

New Name: _____ Former Name: _____
 New Address: _____
 City: _____ State: _____ Zip Code: _____ Phone: _____

Section 4: CHANGE IN BENEFICIARY (Life Insurance only)

Primary Beneficiary: _____ Relationship: _____
 Secondary Beneficiary: _____ Relationship: _____

Section 5: PAYROLL AUTHORIZATION

I request the indicated change(s) be made. I authorize payroll deductions from my earnings to provide the Coverage requested above

Employees Signature: _____ Date _____

Employers Signature: _____ Effective date of change: _____