



Medical, Dental and Vision Change Form

Please print clearly.

Request for changes must be submitted within 30 days of a qualifying event.

Employee Information				
Worksite Employer		Employee Last Name		First Name
				Social Security Number
Contact information, if needed to process form.	Home Phone:	Cell Phone:	Email:	

Drop All Coverage with a Qualifying Event		
<input type="checkbox"/> Health	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision

Drop date _____. Due to:
 Employee no longer working 30 hours per week
 Employee and all dependents are eligible for other group coverage. *Letter of Creditable Coverage with start date required.

Drop Dependents				
<input type="checkbox"/> From Health		<input type="checkbox"/> From Dental		<input type="checkbox"/> From Vision
<u>Due to:</u>	<u>Effective Date:</u>	<u>Documentation Required:</u>		
<input type="checkbox"/> Dependent Child's Age	*Date of dependent's 26 th birthday: _____	None		
<input type="checkbox"/> Divorce	*Date no longer living together: _____	None		
<input type="checkbox"/> Other Group Coverage	*Start date of New Coverage: _____	*Letter of Creditable Coverage with start date		
Last Name	First Name	M.I.	Gender	Date of Birth
Last Name	First Name	M.I.	Gender	Date of Birth
Last Name	First Name	M.I.	Gender	Date of Birth
Last Name	First Name	M.I.	Gender	Date of Birth

* Required

Add Dependents				
<input type="checkbox"/> To Health		<input type="checkbox"/> To Dental		<input type="checkbox"/> To Vision
<u>Due to:</u>	<u>Effective Date:</u>	<u>Documentation Required:</u>		
<input type="checkbox"/> Birth of Dependent	*Date of dependent's birth: _____	*Copy of Birth Certificate		
<input type="checkbox"/> Marriage	*Date of marriage: _____	*Copy of Marriage Certificate		
<input type="checkbox"/> Adoption of Dependent	*Date placed in the home: _____	*Copy of Adoption Papers		
<input type="checkbox"/> Loss of Group Coverage	*Termination Date: _____	*Letter of Creditable Coverage with end date		
<input type="checkbox"/> Late Enrollments (Health Only)	Contact your Client Acct Manager for eligibility.	None		
Last Name	First Name	M.I.	Gender	Date of Birth
Last Name	First Name	M.I.	Gender	Date of Birth
Last Name	First Name	M.I.	Gender	Date of Birth
Last Name	First Name	M.I.	Gender	Date of Birth

* Required

Change of Name or Address	
Change Name To:	Change Mailing Address To:

Employee Signature and Certification of Information Accuracy	
<p>I understand the information presented to me about these plans, and I have made the coverage selections represented on this form. I authorize A Plus Benefits to make deductions from my earnings for my share of the cost, if any, of the benefits to which I may become entitled. I also understand that coverage may only be dropped on January 1st, or within 30 days of becoming eligible for another group plan of the same type. I certify that the information I have provided on this form is true and complete. I understand that giving false or incomplete information may result in the retroactive loss of this coverage. I understand that I must work at least 30 hours per week to remain eligible for these benefit plans. A photocopy of this form shall be as valid as the original.</p>	
<p>X _____ Employee Signature</p>	<p>_____ Date</p>

Office Use Only		
Qualifying Event:	Effective Date:	Instructions:

