BENEFITS CHANGE FORM

Type of Change ☐ **Name** ☐ **Address** ☐ **Termination** ☐ **Dependent Status** ☐ **Family Additions**

Employee Last Name , First Name	Social Security Number

Name Change

Employee New Name

Termination of your coverage additional documentation is required

Medical ☐ Dental ☐ Vision ☐	Reason:

Address Change

Employee New Address
City / State / Zip Code
New Phone Number

Change in Dependent Status additional documentation is required

☐ Add Spouse – Effective Date:
Reason:

☐ Add Child – Effective Date:
Reason:

☐ Remove Dependent – Effective Date:
Reason: Name:

Family Additions (check MEDICAL/DENTAL boxes for coverage)
Marriage certificate required to add spouse and birth certificate(s) required to add children (unless previously provided)

Last Name , First Name	SSN	DOB	Sex M/F	Relation to Employee	MEDICAL	For HMO only Doctor #[1]	Current Y/N	DENTAL	For HMO only Dentist #[1]	Current Y/N	VISION
					☐			☐			☐
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Submit this form along with required back-up documentation within 30 days of your qualified change in status via the SECURE WEB LINK FOR EMPLOYEE FORMS posted on the benefits website (drag & drop). Faxes & scans to emails will not be accepted.
Need help? Call Benefits 818-331-1041/818-972-0787.

Employee Signature _____ **Date**

I have read and understand the provisions set out on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued or terminated under the plan. Any misstatements or omissions may result in future claims being denied and/or my coverage being rescinded.

[1] Use Provider Search at www.aetna.com to find Primary Medical/Dental Office IDs