UMCHS BENEFIT CHANGE/UPDATE FORM

PERSONAL INFORMATION

Employer Name

Last Name	First Name	Social Security Number

Home Address

City	State	Zip	Home Phone

CHANGE/UPDATE INFORMATION

Date of Status Change

- ☐ Change of Beneficiary (List New Beneficiary) ____________________
- ☐ Name Change (Supply Old Name) ____________________
- ☐ New Address (Supply Old Address) ____________________
- ☐ Terminating Coverage (List Benefit and Reason ____________________
- ☐ Adding Dependent (Complete Dependent Information Below)
- ☐ Deleting Dependent (Complete Dependent Information Below)

DEPENDENT INFORMATION

	Name of Person	Date of Birth	Gender	Type of Coverage Medical/Dental/Vision
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				

SIGNATURE ____________________ DATE ____________________