

Benefit Change in Participation Form

Please return to the Personnel department

Associate: _____

Clock #: _____

Department: _____

Location: _____

Please note: All changes must be made within 30 days of the qualifying event.

I would like to (please mark one)

- Terminate the following coverage(s) entirely:
 Health Dental Vision

- OR**
 Add a dependent Delete a dependent

Complete below if adding or deleting dependents or to designate which dependent(s)/coverage(s)

Dependent	Social Security Number	M/F	DOB	Medical		Dental*		Vision	
				Add	Remove	Add	Remove	Add	Remove

* Please note if you are adding new dependents to the dental coverage, some Class 2 and Class 3 procedures have a 12-month waiting period.

Reason for change:

- Marriage Birth of dependent Adoption
- Death of spouse/dependent Divorce Dependent no longer eligible
- Loss of coverage (Please provide a Certificate of Coverage from other Plan)
- Other coverage

Effective date of change: _____

Signature

Date