INSURANCE AND BENEFIT CHANGE FORM

EMPLOYEE INFORMATION			
NAME (Last, First, MI)	SSN	DOB	EMP ID
ADDRESS, CITY AND ZIP		PHONE: ( )	DEPT:

QUALIFYING EVENT (REASON) FOR REQUESTED CHANGE **Date of Event: _____**

*****Documentation must be attached****

- ☐ Birth/Adoption of Child
- ☐ Death of Spouse/Dependent
- ☐ Gain/Loss of Employment for Spouse
- ☐ Marriage/Divorce
- ☐ Military Leave/Return
- ☐ Dependent's Loss of Eligibility
- ☐ Change from/to Part-Time/Full-time, Spouse/Employee
- ☐ Unpaid Leave of Absence, Spouse/Employee
- ☐ Substantial Change in Insurance Coverage due Spouse Employment
- ☐ Other: _____

CHANGE IN TERM LIFE BENEFICIARY

BENEFICIARY NAME (Last, First, MI)	GENDER (M/F)	SSN	DOB	MARITAL STATUS
ADDRESS (IF OTHER THAN EMP)	PHONE ( )	PRIMARY/SECONDARY	PERCENT %	RELATIONSHIP
BENEFICIARY NAME (Last, First, MI)	GENDER (M/F)	SSN	DOB	MARITAL STATUS
ADDRESS (IF OTHER THAN EMP)	PHONE ( )	PRIMARY/SECONDARY	PERCENT %	RELATIONSHIP

CHANGE IN GROUP HEALTH INSURANCE

Plan Name: HDHP Value

From: ☐ Waive	To: ☐ Waive
☐ Employee Only	☐ Employee Only
☐ Emp/Spouse	☐ Emp/Spouse
☐ Emp/Children	☐ Emp/Children
☐ Emp/Family	☐ Emp/Family

CHANGE IN DENTAL or VISION BENEFIT PROGRAM

Plan Name: Dental Basic Vision Dental Expanded

From: ☐ Waive	To: ☐ Waive
☐ Employee Only	☐ Employee Only
☐ Emp/Spouse	☐ Emp/Spouse
☐ Emp/Children	☐ Emp/Children
☐ Emp/Family	☐ Emp/Family

CHANGE IN TERM LIFE INSURANCE

Application May Be Required Requested New Volume: $_____

From: ☐ Waive	To: ☐ Waive
☐ Supplemental	☐ Supplemental
☐ Optional	☐ Optional
☐ Spouse	☐ Spouse
☐ Child	☐ Child

CHANGE IN FLEXIBLE REIMBURSEMENT ACCOUNTS (FSA)

Medical FSA: I request my annual pledge from _____ to _____ for eligible medical expenses; and/or
Child Care FSA: I request changing my annual pledge from _____ to _____ for eligible child care expenses.

CHANGE IN DEPENDENT INFORMATION

ADD/ DROP	DEPENDENT NAME LAST, FIRST MI	DOB	SEX M/F	SSN	RELATION	EFFECTIVE DATE

Tobacco Surcharge (excludes Fire and Police medical plans)

Have you and/or your spouse used any of the following within the last three months?

- Any tobacco product, including cigarettes, cigars, chewing tobacco, snuff or pipe tobacco.
- Any unregulated nicotine device, such as e-cigarettes or vaporizers, used four or more times per week.

Employee □ Yes □ No Spouse □ Yes □ No

I acknowledge that I have received and understand the insurance and benefits information regarding the above changes that I seek. I authorize the City of Corpus Christi to deduct from my earnings the amount to cover my share of the contribution for coverage under the Group Health Benefit Plan(s) in which I have enrolled and/or changed based upon my qualifying event above. If I continue insurance and benefits while not actively-at-work or as an eligible retiree, I agree to pay my premiums as required. I understand that I cannot change my Group Health Benefit Plan(s) until next enrollment period. I realize that any coverage I am eligible for at this time and for which I do not enroll, may not be available in the future unless I furnish satisfactory evidence of good health as required and at my own expense, as allowed by plan provisions.

Signature: _____ Date: _____

Infor Entry Date:_____ Infor Entry Initials: _____ Tobacco Use/Lifestyle Credit Updates:_____