

CHANGE REQUEST FORM FOR CURRENTLY ENROLLED SUBSCRIBERS CBX DENTAL AND VISION

GENERAL INSTRUCTIONS

Employees use **this form** to update personal information or to add/delete coverage.
Employers use the Employee **Termination Form** to notify us of coverage termination due to a Qualifying Event.
Active Employees use the **Coverage Declination Form** to voluntarily cancel one of more types of coverage.

This Form must be received by the Plan Administrator no later than 30 days after the qualifying event takes place in order to qualify for coverage.
Late submissions will be subject to medical underwriting by the insurance carrier.

* **Additions** to coverage will become effective on the **first day** of the month **following event** (marriage, birth, loss of coverage, other).

* **Cancellations** of coverage will take effect on the **last day** of the month **after receipt** of your request by the plan administrator.

* Please attach a copy of marriage certificate or legal documents as applicable.

Please print in blue or black ink

Reason for Change: Name Address Add/Delete Dependents QE (Choose reason below and attach proof of Change*.)

Type of Qualifying Event (choose one):

- Marriage* Death Birth/Adoption
 Divorce* Loss of Coverage* Other

SECTION 1: EMPLOYEE INFORMATION

Date of Event (i.e. date of birth, date moved, married, last day of coverage, etc): / /	Requested Effective Date: / /	Effective date will be the 1 st of the month following waiting period.
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Name of Company		
Employee Last Name as Originally Enrolled	Employee First Name	M.I.
Employee Social Security Number	Date of Birth (mm/dd/yyyy)	

SECTION 2: NAME/ADDRESS CHANGE (complete this section only if reporting a name or address change)

NEW Last Name	First Name	M.I.
NEW Physical Address (Physical Address, no PO boxes)	Apt #	City State Zip Code
NEW Mailing Address (If Different)	Apt #	City State Zip Code

SECTION 3: COVERAGE CHANGE (Complete only if you are an Active Employee who wants to Add or Cancel Dependents)

DEPENDENT GRID	SPOUSE/ DOMESTIC PARTNER	CHILD #1	CHILD #2	CHILD #3
TYPE OF CHANGE:	<input type="checkbox"/> ADD <input type="checkbox"/> CANCEL	<input type="checkbox"/> ADD <input type="checkbox"/> CANCEL	<input type="checkbox"/> ADD <input type="checkbox"/> CANCEL	<input type="checkbox"/> ADD <input type="checkbox"/> CANCEL
LAST NAME:				
FIRST NAME:				
SOCIAL SECURITY NUMBER:	- -	- -	- -	- -
DATE OF BIRTH:	/ /	/ /	/ /	/ /
GENDER:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
RELATIONSHIP TO EMPLOYEE:	<input type="checkbox"/> SP <input type="checkbox"/> DP			
DISABLED:¹		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DEPENDENT ENROLLING IN:² (Only check plans that are offered)	<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu	<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu	<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu	<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu

¹ For disabled dependents, please submit an Over Age Dependent Certification or Disabled Dependent Certification in addition to this form.

² Dependents may enroll up to age 26 (except on MetLife if married or not a student and not living at home).

SECTION 4: YOUR LEGAL ACKNOWLEDGEMENT: (Please Read, Sign and Date Below)

MetLife Dental, Vision Service Plan, Blue View Vision, & Landmark Healthplan Enrollees Employee Statement - I request coverage under my employer's group insurance plan as noted and also verify the accuracy of the employee section. Furthermore, I authorize my employer to deduct from my earnings any payment, if applicable for this coverage.

X

EMPLOYEE SIGNATURE TO ENROLL IN COVERAGE DATE

PRINT NAME