



Change Form Gossner Foods

Complete Applicable Sections Only

Employee Name _____ Social Security # _____ Date of Birth _____

A. EMPLOYEE INFORMATION CHANGE

Name Changed From _____ Marital Status Change Legally Married Divorced Death

Name Changed To _____ Date of Marital Change _____

New Address _____

City _____ State _____ ZIP _____ New Ph# _____

B. ADD DEPENDENT

Use this section only to add newborn children, adopted children, or children placed for adoption. This Change Form must be submitted within **31 days** from the child's date of birth, adoption, or placement for adoption. All other dependents must submit a completed Employee Application.

	Last Name	First Name	Initial	Coverage			Sex	SSN	Date of Birth (MM/DD/YY)
				Medical	Dental	Vision			
1.							M/F		
2.							M/F		

C. DELETE FAMILY MEMBERS

Delete Children

	Last Name	First Name	Initial	Coverage			Effective Date (MM/DD/YY)	Reason
				Medical	Dental	Vision		
1.								
2.								
3.								

Delete Spouse

	Last Name	First Name	Initial	Coverage			Effective Date (MM/DD/YY)	Reason
				Medical	Dental	Vision		

- Death Annulment
- Divorce Other
- Open Enrollment

If you are deleting coverage for your spouse as a result of a divorce or annulment, please complete the following:

- If you have family coverage, you must submit the first and last page of the divorce decree and any page specifying coverage responsibilities for dependent children.
- If you do not have family coverage, your spouse may sign this form below acknowledging the request to discontinue coverage, or you may submit a copy of the first and last page of the divorce decree.

By signing this form, I acknowledge that I will no longer have healthcare coverage. I understand that I may have rights to continue coverage as the result of my recent divorce and that additional information regarding how to continue coverage may be obtained through the Plan sponsor (spouse's employer).

Spouse's Signature _____ Date _____

Except for when spouse is deceased or at open enrollment, spouse's signature is required.

D. EMPLOYEE TERMINATION OF MEDICAL, DENTAL AND/OR Vision BENEFITS (Check any applicable boxes for employee only)

Actual Date of Change _____ (Last day worked/lost eligibility/retired, etc.)

- Termination of employment
- Retirement
- Death (employee signature not required)
- Leaving for active military service
- Loss of eligibility (i.e. full to part-time but still employed)
- Waiving coverage (due to coverage under a spouse or parent plan)
 - Medical Dental *must submit a waiver form*
- No longer want coverage (subject to group participation requirements)
 - Medical Dental Vision

E. EMPLOYEE SIGNATURE

By signing, you agree to the changes requested above.

Employee's Signature _____ Date _____

F. EMPLOYER INFORMATION (Must be completed)

Employer's Signature _____ Date _____

Company Name _____

Comments _____