Texas Annual Conference
Group Health Benefits Change Form

(To be used only for eligible changes outside of the Open Enrollment Period.)

For Office Use Only
Effective Date:

_____

INSTRUCTIONS

1. Please type or print legibly. Complete the top section of this form.
2. Complete any other section(s) below that pertain to the change(s) you want to make. **This form must be signed and dated to be valid.**
3. If you need to add or terminate additional dependents more than space allows, please complete additional forms as needed.

Employee's Name _____
Last First Middle

Social Security Number _____ Date of Birth _____

CHANGE of NAME, ADDRESS, PHONE or EMAIL

Prior Name _____ New Name _____
Last First Middle Last First Middle

New Address _____
Street City State Zip

New Phone _____
Cell Work Home

New Email _____
Work Home

ADD DEPENDENT COVERAGE (Dependents must be added within 31 days of marriage, date of birth or qualifying loss of coverage. Dependents not enrolled within 31 days can only be enrolled during the annual open enrollment period.)

I want to add coverage for the following dependent(s). (Qualifying dependent loss of coverage cannot be due to non-payment of premium.)

Spouse _____ Date of Birth _____ Sex _____

SS# _____ Qualifying Event (Marriage, Loss of Coverage) _____

Date of Qualifying Event _____ Check all coverages adding: Medical _____ Dental _____ Vision _____

Child_____ Date of Birth _____ Sex _____

SS# _____ Qualifying Event (Birth, Adoption, Loss of Coverage) _____

Date of Qualifying Event _____ Check all coverages adding: Medical _____ Dental _____ Vision _____

TERMINATE DEPENDENT COVERAGE

I want to terminate coverage for the following dependent(s):

Spouse _____ Date of Birth _____ Sex _____

SS# _____ Qualifying Event (Divorce, Other Coverage) _____

Date of Qualifying Event _____ Check all coverages terminating: Medical _____ Dental _____ Vision _____

Child_____ Date of Birth _____ Sex _____

SS# _____ Qualifying Event (Other Coverage) _____

Date of Qualifying Event _____ Check all coverages terminating: Medical _____ Dental _____ Vision _____

PAYROLL AUTHORIZATION

I request the indicated change(s) be made. I authorize the appropriate payroll deductions or electronic funds transfers to provide the coverage requested (if additional funds are required).

Employee's Signature _____ Date _____

Return completed, signed form to: **Texas Annual Conference Benefits Office, 5215 Main St., Houston, TX 77002**
Fax: 713-521-7516 **Email:** atbertrand@txcumc.org
Phone: 713-533-3723 or 1-800-606-0350