Texas Annual Conference
Group Health Benefits Change Form

(To be used only for eligible changes outside of the Annual 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 _____ Date of Birth_____
First Middle Last Suffix

Current Address _____
(or Former) if New Address Street City State Zip

CHANGE of NAME, ADDRESS, PHONE or EMAIL

Prior Name _____
First Middle Last Suffix

New Name _____
First Middle Last Suffix

New Address _____
Street City State Zip

New Phone _____ New Email_____
Cell Work

ADD DEPENDENT COVERAGE: Dependents must be added within 31 days of marriage, date of birth or adoption, or qualifying loss of coverage. Dependents not enrolled within 31 days can only be enrolled during Annual Open Enrollment.

I want to add coverage for the following dependent(s). (Dependent loss of coverage *must be due to loss of eligibility for prior coverage*.)

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: Coverage will term the first of the month after receipt of documentation.

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: **TAC Benefits Office, 5215 Main St., Houston, TX 77002 Attn: Marianela Morales**
Email: mmorales@txcumc.org **Fax: 713-521-7516 Direct: 713-533-3723 Rev. 7-6-2022**