Texas Annual Conference
United Methodist Church

TAC GHB Change Form

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

For Office Use Only
Effective Date:
_____

INSTRUCTIONS: Please complete the top section of this form. 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.*

Employee's Name _____ Date of Birth_____
First Middle Last Suffix

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

SECTION 1: 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_____

SECTION 2: 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. Dependent loss of coverage *must be due to loss of eligibility for prior coverage*. Please note, there is no extra cost when additional children are added due to birth, adoption, or qualifying loss of prior coverage to your GHB plans when the employee has Family coverage in either their medical, dental, or vision plan.

Spouse _____ Date of Birth _____ Sex _____

SSN _____ Please check the Qualifying Event: Marriage ☐ Loss of Prior Coverage ☐

Date of Qualifying Event _____ Check all plans adding coverage: **Medical** ☐ **Dental PPO** ☐ **Vision** ☐

Child_____ Date of Birth _____ Sex _____

SSN_____ Please check the Qualifying Event: Birth ☐ Adoption ☐ Loss of Prior Coverage ☐

Date of Qualifying Event _____ Check all plans adding coverage: **Medical** ☐ **Dental PPO** ☐ **Vision** ☐

SECTION 3: TERMINATE DEPENDENT COVERAGE

Coverage will terminate the first of the month after receipt of documentation. I want to terminate coverage for the following dependent(s):

Spouse _____ Date of Birth _____ Sex _____

SSN _____ Please check the Qualifying Event: Divorce ☐ Other Coverage ☐

Date of Qualifying Event _____ Check all plans terminating: **Medical** ☐ **Dental PPO** ☐ **Vision** ☐

Child_____ Date of Birth _____ Sex _____

SSN _____ Qualifying Event: Other Coverage

Date of Qualifying Event _____ Check all plans terminating: **Medical** ☐ **Dental PPO** ☐ **Vision** ☐

SECTION 4: 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 preferably by email to: Marianela Morales mmorales@txcumc.org, or Fax: 713-521-7516