



# TAC U65 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.

Identify and check your eligibility status below. I am a:

U65 Retiree

U65 Surviving Spouse

U65 Spouse of a Retired Clergy

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: TERMINATE DEPENDENT COVERAGE

I understand that once I authorized the termination of a dependent, that dependent loses the eligibility to enroll in my coverage at any future time. Note that 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 3: EFT AUTHORIZATION

I request the indicated change(s) be made. I authorize the appropriate electronic funds transfers to provide the coverage requested (if additional funds are required). I understand that once I authorized the termination of a dependent, that dependent loses the eligibility to enroll in my coverage at any future time. Please note that an electronic signature is valid.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Return completed, signed form preferably by email to: Patricia Goforth-Rakes [pgrakes@txcumc.org](mailto:pgrakes@txcumc.org), or Fax: 713-521-7516