City of Corpus Christi

# INSURANCE AND BENEFIT CHANGE FORM

****Shaded Areas Must Be Complete****

## EMPLOYEE INFORMATION

| NAME (Last, First, MI) | SSN | DOB | EMP ID |
|---|---|---|---|
| | | | |
| ADDRESS, CITY AND ZIP | | PHONE: ( ) | DEPT: |
| | | | |

**QUALIFYING EVENT (REASON) FOR REQUESTED CHANGE** **Date of Event: _____**

*****Documentation must be attached****

- ☐ Birth/Adoption of Child
- ☐ Marriage/Divorce
- ☐ Change from/to Part-Time/Full-time, Spouse/Employee
- ☐ Substantial Change in Insurance Coverage due Spouse Employment
- ☐ NMSN-As per Court Order
- ☐ Military Leave/Return
- ☐ Death of Spouse/Dependent
- ☐ Dependent's loss of eligibility
- ☐ Unpaid Leave of Absence, Spouse/Employee
- ☐ Gain/Loss of Employment for Spouse

## CHANGE IN TERM LIFE BENEFICIARY

| BENEFICIARY NAME (Last, First, MI) | GENDER (M/F) | SSN | DOB | MARITAL STATUS |
|---|---|---|---|---|
| | | | | |
| ADDRESS (IF OTHER THAN EMP) | PHONE ( ) | PRIMARY/SECONDARY | PERCENT % | RELATIONSHIP |
| | | | | |
| BENEFICIARY NAME (Last, First, MI) | GENDER (M/F) | SSN | DOB | MARITAL STATUS |
| | | | | |
| ADDRESS (IF OTHER THAN EMP) | PHONE ( ) | PRIMARY/SECONDARY | PERCENT % | RELATIONSHIP |
| | | | | |

### CHANGE IN GROUP HEALTH INSURANCE

Plan Name:

| From: | To: |
|---|---|
| ☐ None | ☐ None |
| ☐ Employee Only | ☐ Employee Only |
| ☐ Emp/Spouse | ☐ Emp/Spouse |
| ☐ Emp/Children | ☐ Emp/Children |
| ☐ Emp/Family | ☐ Emp/Family |

### CHANGE IN DENTAL or VISION BENEFIT PROGRAM

Plan Name:

| From: | To: |
|---|---|
| ☐ None | ☐ None |
| ☐ Employee Only | ☐ Employee Only |
| ☐ Emp/Spouse | ☐ Emp/Spouse |
| ☐ Emp/Children | ☐ Emp/Children |
| ☐ Emp/Family | ☐ Emp/Family |

### CHANGE IN TERM LIFE INSURANCE

**Application May Be Required**

Requested New Volume: $_____

| From: | To: |
|---|---|
| ☐ None | ☐ None |
| ☐ Supplemental | ☐ Supplemental |
| ☐ Optional | ☐ Optional |
| ☐ Spouse | ☐ Spouse |
| ☐ Child | ☐ Child |

## CHANGE IN FLEXIBLE REIMBURSEMENT ACCOUNTS (FSA)

Medical FSA: I request my annual pledge from _____ to _____ for eligible medical expenses; and/or
Child Care FSA: I request changing my annual pledge from _____ to _____ for eligible child care expenses.

## CHANGE IN DEPENDENT INFORMATION

| ADD/ DROP | DEPENDENT NAME LAST, FIRST MI | DOB | SEX M/F | SSN | RELATION | EFFECTIVE DATE |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

I acknowledge that I have received and understand the insurance and benefits information regarding the above changes that I seek. I authorize the City of Corpus Christi to deduct from my earnings the amount to cover my share of the contribution for coverage under the Group Health Benefit Plan(s) in which I have enrolled and/or changed based upon my qualifying event above. If I continue insurance and benefits while not actively-at-work or as an eligible retiree, I agree to pay my premiums as required. I understand that I cannot change my Group Health Benefit Plan(s) until next enrollment period. I realize that any coverage I am eligible for at this time and for which I do not enroll, may not be available in the future unless I furnish satisfactory evidence of good health as required and at my own expense, as allowed by plan provisions.

Signature: _____ Date: _____

PS Entry Date: _____ PS Entry Initials: _____