BENEFITS CHANGE FORM

Type of Change ☐ **Name** ☐ **Address** ☐ **Termination** ☐ **Dependent Status** ☐ **Family Additions**

Last Name , First Name	Social Security Number

Name Change

New Name

Termination of your coverage additional documentation is required

Medical ☐ Dental ☐ Vision ☐	Reason:

Address Change

New Address
City / State / Zip Code
New Phone Number

Change in Dependent Status additional documentation is required

☐ Add Spouse – Effective Date:
Reason:

☐ Add Child – Effective Date:
Reason:

☐ Remove Dependent – Effective Date:
Reason: Name:

Family Additions (check MEDICAL/DENTAL boxes for coverage)

Marriage certificate required to add spouse and birth certificate(s) required to add children (unless previously provided)

Last Name , First Name	SSN	DOB	Sex M/F	Relation to Employee	MEDICAL	For HMO only Doctor #[1]	For HMO only Current Y/N	DENTAL	For HMO only Dentist #[2]	For HMO only Current Y/N	VISION
					☐			☐			☐
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Return this form along with proof within 30 days of your qualified change in status to BENEFITS, 3500 W. Olive Avenue #1000, Burbank, CA 91505, OR use the secure web link EMPLOYEE FORMS (save first in your computer, then upload)

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Employee Signature **Date**

I have read and understood the provisions set out on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued or terminated under the plan. Any misstatements or omissions may result in future claims being denied and/or my coverage being rescinded.

[1] Use DocFind at www.aetna.com to find Primary Medical Office ID
[2] Use DocFind at www.aetna.com to find Primary Dental Office ID