

CHANGE FORM

This form must be returned to your Business Manager/Clerk. Do not submit directly to MUST.

1	School District Name:	Group No:	Effective Date:
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- ADDRESS CHANGE
 NAME CHANGE – Please indicate YOUR PRIOR name so we can correctly identify you: _____

FIRST NAME:	MI:	LAST NAME:	LAST 4 OF SSN #:
MAILING ADDRESS:	CITY:	STATE:	ZIP:
PHONE NUMBER:			

WORK E-MAIL: _____

2	Please indicate type of change below.
<input type="checkbox"/> DROP HEALTH BENEFITS FOR ALL <input type="checkbox"/> CHANGE BENEFICIARIES (fill out section 4)	
<input type="checkbox"/> ADD DEPENDENT <input type="checkbox"/> DROP DEPENDENT	
<input type="checkbox"/> STATUS CHANGED TO RETIRED (You must provide Teachers' Retirement or Public Employees' Systems documentation) DATE: _____	
<input type="checkbox"/> PLAN CHANGE W/ SPECIAL ENROLLMENT: FROM: _____ TO: _____	

3	REASON FOR ADD/CHANGE	Date of Event	REASON FOR DROP	Date of Event
	Open Enrollment		Divorce or Legal Separation (Provide address for COBRA notice)	
	Birth, Adoption, Legal Guardianship (attach legal documentation)		Cost	
	Marriage (date of marriage required)		Medicare Eligible	
	Loss of Other Coverage REQUIRED: Reason for Loss of Coverage		Dropping Health Benefit	
	_____		Other Coverage	
	(Proof of loss required)		Death	
			Other (explain)	

If you are adding or dropping a Dependent, please list their information below.

First Name MI Last Name	Gender	Social Security #	Date of Birth	Relationship	Medical		Dental		Vision	
					Add	Drop	Add	Drop	Add	Drop
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF DROPPING COVERAGE: I understand that dropping coverage completely may affect my ability to obtain coverage at a later date for myself and my family, except during applicable "Special Enrollment periods" as defined by the Plan Document. I acknowledge that I am also dropping the Basic Life Insurance and Long Term Disability (LTD) benefit provided by the plan, unless I am covered by MUST as a dependent under another policy provided by the same employer. (If covered under another medical coverage complete the Beneficiary section of this application.)

4	LIFE INSURANCE BENEFICIARIES (Changes all Life Benefits)						
	Primary – Full Name	Mailing Address	SSN	Date of Birth	Relationship	% of Benefit	
	Contingent – Full Name	Mailing Address	SSN	Date of Birth	Relationship	% of Benefit	

5	I certify that the information on this form is true and accurate. I UNDERSTAND that providing inaccurate or incorrect information on this form may be considered health care fraud.	FOR MUST USE ONLY: Date Entered ____/____/____ NOTES: _____ Q/A INIT _____
	Employee Signature (required) _____	Date _____