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:

☐ 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.

☐ DROP HEALTH BENEFITS FOR ALL ☐ CHANGE BENEFICIARIES (fill out section 4)

☐ ADD DEPENDENT ☐ DROP DEPENDENT

☐ STATUS CHANGED TO RETIRED (You must provide Teachers' Retirement or Public Employees' Systems documentation) DATE: _____

☐ PLAN CHANGE W/ SPECIAL ENROLLMENT: FROM: _____ TO:_____

3

REASON FOR ADD/CHANGE	Date of Event
Open Enrollment	
Birth, Adoption, Legal Guardianship (attach legal documentation)	
Marriage (date of marriage required)	
Loss of Other Coverage **REQUIRED: Reason for Loss of Coverage** _____ *Proof of loss required	

REASON FOR DROP	Date of Event
Divorce or Legal Separation (Provide address for COBRA notice)	
Cost	
Medicare Eligible	
Dropping Health Benefit	
Other Coverage	
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
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐	☐

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, or employer offers LTD non-medical participating coverage. (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.

_____

Employee Signature (required) **Date**

FOR MUST USE ONLY: Date Entered ____/____/____

NOTES: _____Q/A INIT_____

Change Form revised 02/27/2020