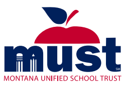

CHANGE FORM

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	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** ________________________ *Proof of loss required		**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 Add	Medical Drop	Dental Add	Dental Drop	Vision Add	Vision 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.

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

NOTES: ______________________Q/A INIT_____

____

Employee Signature (required) **Date**