

To ensure that appropriate coverage is provided, please submit all changes within 31 days of eligibility of coverage.
 Please use reverse side to report multiple certificate changes for one division.

Name of Policyholder	Policy No.	Division No.
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1. <input type="checkbox"/> Addition of Dependent Coverage <input type="checkbox"/> Additions to Dependent Coverage <input type="checkbox"/> Changes to Dependent Coverage	Name of Employee	Certificate Number
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Name of All Eligible Dependents Last Name, First Name and Initials	Sex M / F	Relationship to insured. Complete only if not legal spouse or legally adopted or natural child	Date of Birth			Dependent Status S = Student, College, Univ. X = Disabled	Other Existing Coverage		* Date Acquired		
			Month	Day	Year		Health Yes/No	Dental Yes/No	Month	Day	Year
Spouse											
Child											
Child											
Child											
Child											

* 1. For an eligible spouse, state date of marriage or co-habitation
 2. For eligible children, state date of dependency.

Date _____ Signature of Employee _____

2. Termination of Dependent Coverage	Name of Employee	Certificate Number
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I no longer have eligible dependents and request single coverage effective

Month	Day	Year

I wish to terminate dependent(s) as indicated below.

Name of Dependent	Date Terminated		
	Month	Day	Year

Date _____ Signature of Employee _____

3. Termination of Employee Coverage	Name of Employee	Certificate Number
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Termination of Employment Reason (if other than voluntary termination of employment)

Other

Month	Day	Year

4. Change of Employee Name	Old Name of Employee	Certificate Number
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New Name of Employee _____ Reason _____

5. Change of Salary	Name of Employee	Certificate Number
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New Gross Annual Salary \$ _____

Month	Day	Year

6. Change of Class or Division	Name of Employee	Certificate Number
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Class Old Class _____ New Class _____
 Division Old Division _____ New Division _____

Reason _____

Month	Day	Year

Date _____ Telephone Number _____ Signature of Authorized Official _____

