

DENTAL INSURANCE-GROUP BENEFIT SERVICES INC.
EMPLOYEE RECORD CHANGE

EMPLOYER OF INSURED: MACOMB INTERMEDIATE SCHOOL DISTRICT Group #: 1032
PLAN ADMINISTRATOR: Group Benefit Services, Inc.
School Administrative Services, Inc.

Employee Name: _____
Social Security Number: _____
Address (indicate only if new): _____

Request for additional Health ID cards: # of cards needed _____, reason for request: _____
Request for additional Paid Pres. cards: # of cards needed _____, reason for request: _____

ADDITIONS OR DELETIONS

- Employee name change (name on Employee Data Information form) _____
New name (first/middle/last) _____
Reason for change _____ Effective date _____
- Marriage to (first/middle/last name) _____
Date occurred _____ Spouse's birthdate _____ SS# _____
Type of coverage for spouse, Medical—Dental—Vision (circle appropriate coverage) _____
Effective date for above coverage _____
Is your spouse employed? Yes No If yes, indicate name and address of employer on reverse side.
Does your spouse have medical, dental, and/or vision coverage through his/her employer? Yes No If yes, indicate name and address of insurance carrier(s) on reverse side.
Is your spouse eligible for Medicare? Yes No
- Birth or Legal Adoption/Guardian of a child (first/middle/last name) _____
Date of Birth _____ Relationship to Employee, son or daughter _____
Type of coverage for child, Medical—Dental—Vision (circle appropriate coverage) _____
Effective date for above coverage _____
- Stepchild* (first/middle/last name) _____
Date of Birth _____ Relationship to Employee, step-son or step-daughter _____
Type of coverage for child, Medical—Dental—Vision (circle appropriate coverage) _____
Effective date for above coverage _____
- Death of Employee or Dependent (first/middle/last name) _____
Date occurred _____ Effective date to remove from Plan _____
- Divorce of Employee from (first/middle/last name) _____
Date occurred _____ Effective date to remove from Plan _____
- Marriage of a dependent (first/middle/last) _____
Date occurred _____ Effective date to remove from Plan _____
- Terminate insurance coverage for Employee and dependents:
Date occurred _____ Effective date to remove from Plan _____
Reason for termination of insurance coverage _____
- OTHER _____

employee signature _____

Employer Authorized Signature _____

Date Signed _____

*list additional step children on the reverse side of this form.

(For your records, we suggest that you do not implement any changes without written consent of the employee)

Spouse Insurance Coverage

Name of Employer: _____

Address: _____

_____ Zip _____

Telephone: _____

Name of Insurance Carrier(s):

Health: _____

Dental: _____

Vision: _____

Dependent Insurance Coverage

Name of Insurance Carrier(s):

Health: _____

Dental: _____

Vision: _____

If parents are divorced or legally separated, has dependent(s) coverage through any other insurance carrier(s):

Yes No

If yes, please complete the questions below:

Relationship to Dependent: _____

Date of Birth of Parent: _____

Name of Insurance carrier(s):

Health: _____

Dental: _____

Vision: _____

Additional information that may be beneficial:

