REQUEST FOR EMPLOYEE CHANGE

Employer: County of Dakota County Group # 30071373

Employee Name: _____ SSN # _____

1. I wish to make the following changes to my Health coverage ☐ Dental Coverage ☐ (Check all that apply):

☐ Add Dependent Coverage for the following *(List Dependents to be added)*

Dependent Name	SSN #	Sex	Date of Birth	Relationship

Reason for Addition: (Change in family status)

☐ Marriage ☐ Spouse loss of Job ☐ Adoption

☐ Birth ☐ Other _____

Date of Change: _____

2. Decrease or Terminate Dependent coverage *(List Dependent(s) to be dropped)*

Dependent Name	SSN #	Sex	Date of Birth	Relationship

Reason: _____ Effective Date of Change: _____

I understand I will be bound by this eletion and can only add coverage later if my situation is a life change event that is permitted by the IRS Code Section 125, HIPAA regulations.

3. Cancel Coverage:

Reason: _____ Date: _____

4. Change Life Insurance Beneficiary to: _____

5. Change Life Insurance Amount to: _____

6. Change Employees name to: _____

7. Other Change: *(Explain - Division or address, etc.)*

Employees Signature _____ Date: _____

Company Representative _____ Date: _____

Authorized Signature