

UMCHS BENEFIT CHANGE/UPDATE FORM

PERSONAL INFORMATION

Employer Name			
Last Name	First Name	Social Security Number	
Home Address			
City	State	Zip	Home Phone

CHANGE/UPDATE INFORMATION

Date of Status Change

- Change of Beneficiary (List New Beneficiary) _____
- Name Change (Supply Old Name) _____
- New Address (Supply Old Address) _____
- Terminating Coverage (List Benefit and Reason) _____
- Adding Dependent (Complete Dependent Information Below)
- Deleting Dependent (Complete Dependent Information Below)

DEPENDENT INFORMATION

	Name of Person	Date of Birth	Gender	Type of Coverage Medical/Dental/Vision
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				

SIGNATURE

DATE