StirlingBenefits™
Evolving the Business of Benefits℠

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PREMIUM/ADMINISTRATION CHANGES

EFFECTIVE DATE OF CHANGE: _____________ **Employer Name:** ____________________________

Employee's Name: _________________________________ SS #: ________________________

Please check all lines of coverage that this change applies to:

☐ Medical ☐ Rx ☐ Dental ☐ Vision ☐ HRA ☐ HC FSA ☐ Dep. Care FSA ☐ Parking ☐ Transit

1. ☐ Change of Address:(New) ____

   ____

2. ☐ Name Change: ☐ Employee ☐ Spouse ☐ Dependent Child

   From: _____________________________ To: _________________________________

3. ☐ Coverage Termination Date: _____________________ COBRA Eligible? ☐ Yes ☐ No

4. ☐ Effective Date of Change: _____________ First Payroll Date of Change: ____________

5. ☐ FSA Life Event Change Reason: ____

   Old Amount: ____________ New Amount: _______________

6. ☐ Change Employee From Division: _______________ To Division: ___________________

7. ☐ Change Eligibility Status (FT/PT) From: _________________To: ____________________

8. ☐ Change Benefit Coverage (Single/Dual/Family) From: ____________ To: _____________

9. ☐ Additional Dependent(s) to be Covered:_________________________________

   ☐ ___________________ ☐ ___________________
   Date of Marriage Date of Birth

10. ☐ Dependent(s) to be terminated:________________________________

    ☐ ___________________ ☐ ___________________
    Date of Divorce Other

<u>Please Complete for Items 6-8 Above</u>

Dependent(s) Name	**Relationship**	**Date of Birth**
_________________________________	_____________________	__________________
_________________________________	_____________________	__________________
_________________________________	_____________________	__________________

_________________________________ _______________________

EMPLOYER SIGNATURE **DATE**