

# BENEFIT SUPPORT, INC.

P. O. Box 2977  
Gainesville, Georgia 30503

## REQUEST FOR CHANGE

Name of Employer: \_\_\_\_\_ Group No.: \_\_\_\_\_

Employee Social Security No.: \_\_\_\_\_ Division: \_\_\_\_\_

Name of Employee: \_\_\_\_\_

Employee Address (if new): \_\_\_\_\_  
\_\_\_\_\_

### NAME CHANGE

From (Former Name) \_\_\_\_\_

Last Name

First Name

To (Present Name) \_\_\_\_\_

Last Name

First Name

### CHANGE OF BENEFICIARY

Request is hereby made for change of beneficiary to:

Name (First, Middle, Last)

Relationship

### CHANGE IN DEPENDENCY STATUS

FROM: \_\_\_\_\_ Single Coverage  
\_\_\_\_\_ Employee & Spouse  
\_\_\_\_\_ Employee & Children  
\_\_\_\_\_ Employee, Spouse & Children  
\_\_\_\_\_ No Medical

TO: \_\_\_\_\_ Single Coverage  
\_\_\_\_\_ Employee & Spouse  
\_\_\_\_\_ Employee & Children  
\_\_\_\_\_ Employee, Spouse & Children  
\_\_\_\_\_ No Medical

To add or delete Spouse: \_\_\_\_\_

Name	DOB	Date Married	SS#
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To add or delete Children: \_\_\_\_\_

Name	DOB	Sex	SS#
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\_\_\_\_\_

Name	DOB	Sex	SS#
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\_\_\_\_\_

Name	DOB	Sex	SS#
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If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Date Signed \_\_\_\_\_

\_\_\_\_\_  
(Signature)