

# BENEFITHELP

## Solutions



### CHANGE / UPDATE FORM

<b>ORIGINAL QUALIFIED BENEFICIARY</b>			
LAST NAME		FIRST NAME	
STREET			
CITY	STATE	ZIP	
PHONE		SSN	
GROUP NAME			
<b>DATE OF STATUS CHANGE</b>			
<b>TYPE OF STATUS CHANGE/REASON FOR CHANGE</b>			
<input type="checkbox"/> Name Change Only <input type="checkbox"/> New Address <input type="checkbox"/> Adding Dependent _____ <input type="checkbox"/> Deleting Dependent _____ <input type="checkbox"/> Changing Carriers Due to Moving Out of Service Area <input type="checkbox"/> Adding Benefit Due to Status Change/Open Enrollment _____ <input type="checkbox"/> Terminating coverage (list benefit and reason for termination) _____			
<b>New Qualified Beneficiary Information (in the instance of new marriage, birth or adoption, loss of coverage)</b>			
LAST NAME		FIRST NAME	
DOB	If you are adding a newborn, please contact BenefitHelp Solutions when you receive your dependant's SSN. SSN	GENDER    M    F	
<b>New Carrier Information (if moving out of service area or terminating coverage due to new carrier)</b>			
PREVIOUS MEDICAL		PREVIOUS DENTAL	
NEW MEDICAL		NEW DENTAL	
SIGNATURE			DATE