Dependent Change Form

69171207 (4/20)

BenefitHelp SOLUTIONS

PLEASE PRINT CLEARLY

*** This information is mandatory.** Form processing may be delayed if fields with an asterisk are not filled out.

Section 1 Original Qualified Beneficiary

* First name	* Last name	*Social Security Number	
* Address	* City	* State	* Zip
* Phone number	* Group name	* Date of status change	

* Reason for status change

- ☐ Name Change Only _____
- ☐ New Address _____
- ☐ Adding Dependent _____
- ☐ Deleting Dependent _____
- ☐ Changing Carriers Due to Moving Out of Service Area _____
- ☐ Adding Benefit Due to Status Change/Open Enrollment _____
- ☐ Terminating coverage (list benefit and reason for termination) _____

Section 2 New Qualifed Beneficiary Information (in the instance of new marriage, birth or adoption, loss of coverage)

* First name	* Last name	* Date of birth
* SSN *(if you are adding a newborn, please contact BenefitHelp Solutions when you receive your dependent's SSN)*	Gender ☐ Male ☐ Female	

Section 3 New Carrier Information (if moving out of service area or terminating coverage due to new carrier)

* Previous medical	* Previous dental
* New medical	* New dental

Section 4 Authorization

I acknowledge that this form may be electronically signed and I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

* Authorized contact signature	* Date

Return the completed form to BenefitHelp Solutions

Mail: BenefitHelp Solutions, PO Box 40548 Portland, OR 97240-0548 **Fax:** 888-393-2943

Questions? Contact BenefitHelp Solutions at 800-556-3137, Monday - Friday 7:30 a.m. to 5:30 p.m. PST.