



# participant information CHANGE FORM

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### FOR COMPANY USE ONLY

Company Name		Division	
Date of Hire	Effective Date	Effected Coverage <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> FSA <input type="checkbox"/> HSA <input type="checkbox"/> Other
			Salary \$

Comments

**Check the boxes below that apply and complete the numbered sections indicated.**

- |   |   |
|---|---|
| <input type="checkbox"/> Employee Name Change ..... 1, 1 A, 2, 3A, 11                 | <input type="checkbox"/> Terminate All Coverage ..... 1, 1 A, 2, 8, 11                      |
| <input type="checkbox"/> Address and/or Phone Number Change ..... 1, 1 A, 2, 3, 11    | <input type="checkbox"/> Salary Change ..... 1, 1 A, 11                                     |
| <input type="checkbox"/> Add Dependent Spouse ..... 1, 1 A, 2, 4, 4A, 5, 8, 10, 11    | <input type="checkbox"/> Change of Beneficiary ..... 1, 1A, 9, 10, 11                       |
| <input type="checkbox"/> Add Dependent Child(ren) ..... 1, 1 A, 2, 4, 4A, 6-8, 10, 11 | <input type="checkbox"/> * Change to COBRA Status for Employee ..... 1, 1A, 2, 8, 11        |
| <input type="checkbox"/> Terminate Dependent Spouse ..... 1, 1A, 2, 5, 8, 10, 11      | <input type="checkbox"/> * Change to COBRA Status for Dependent ..... 1, 1A, 2, 4, 5, 8, 11 |
| <input type="checkbox"/> Terminate Dependent Child(ren) ..... 1, 1 A, 2, 6-8, 10, 11  | <input type="checkbox"/> ** Life Status Change ..... 1, 1A, 8, 11                           |
| <input type="checkbox"/> Division Change ..... 1, 1A, 11                              | <input type="checkbox"/> Other  |

1 Employee Last Name	First Name	Middle Initial	1A Social Security Number
			- -

2 Street Address	Apt. No.	City	State	Zip Code
-				

3 New Home Phone Number	3A Previous Name	4 Spouse's Social Security Number	4A Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
- -		- -	Employer Name

	Last Name	First Name	M I	Date of Birth			Sex	Other Group Health Coverage? With Whom?
				Mo	Day	Yr		
6	Spouse						<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Yes <input type="checkbox"/> No	
6	Child						<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Yes <input type="checkbox"/> No	
7	Child						<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Yes <input type="checkbox"/> No	

8	Reason	<input type="checkbox"/> Newborn <input type="checkbox"/> Marriage <input type="checkbox"/> Employee Medicare Entitlement <input type="checkbox"/> Child No Longer Eligible	<input type="checkbox"/> Death of Employee <input type="checkbox"/> Change in Spouse's Employment <input type="checkbox"/> Employee Reduction in Hours <input type="checkbox"/> Employee Retirement <input type="checkbox"/> Divorce/Legal Separation	<input type="checkbox"/> Voluntary Employment Termination <input type="checkbox"/> In-voluntary Employment Termination <input type="checkbox"/> Resignation <input type="checkbox"/> Employee Retirement <input type="checkbox"/> Divorce/Legal Separation	Date Occurred	
				Mo	Day	Yr

9 Life Insurance Beneficiary

Coverage granted to persons herein shall be subject to all provisions and limitations of the group health plan.  
 \*This is not a COBRA continuation Election form. For changes to COBRA status, attach a copy of the signed election form.  
 \*\*If this qualifies as a Life Status Change under Section 125 plans, a completed enrollment form must be attached.

10 Employee Signature:	Date Signed:
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11 Employer Signature:	Date Signed:
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