

## METLIFE CHANGE REQUEST

**GROUP NAME:** Town of Biscoe

**GROUP NUMBER:** TM05587573

**TYPE OF ELIGIBILITY CHANGE: (Please list below)**

- |                        |  |   |
|------------------------|--|---|
| 1. Name Change         | 6. Partial Cancellation (List Coverages to be Cancelled)         | 11. COBRA Enrollment (Attach Election Form) |
| 2. Address Change      |  | 12. COBRA Termination                       |
| 3. Cancel Spouse       | 7. Cancel All Coverage - Termination of Employment               | 13. Change Employee from DHMO to PPO*       |
| 4. Cancel 1 Child      | 8. Cancel All Contributory Coverage - Request of Active Employee | 14. Change Employee from PPO to DHMO*       |
| 5. Cancel All Children | 9. Change Employee Salary  | 15. Other _____                             |
|                        | 10. Change Insurance Amount due to Salary Change                 |   |

**QUALIFYING EVENTS:**

**DATE:**

- |   |                |
|---|----------------|
| Q1. Add Dependent – Marriage              | ____/____/____ |
| Q2. Add Dependent(s) – Birth or Adoption  | ____/____/____ |
| Q3. Add Dependent(s) – Loss of Coverage** | ____/____/____ |
| Q4. Death                                 | ____/____/____ |
| Q5. Rehired Employee                      | ____/____/____ |
| Q6. Divorce                               | ____/____/____ |
- \*\* Proof of loss is required with submission

All necessary information must be included to avoid processing delays

**COMPLETE FOR ELIGIBLE EMPLOYEE(S)**

ELIGIBILITY OR QUALIFYING EVENT CHANGE		LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER	BIRTHDAY MO/DAY/YR	SEX	LIST NEW CHANGE (SALARY/ADDRESS, ETC.)	COVERAGES AFFECTED
#	EFFECTIVE DATE							
	/ /			- -	/ /			ALL
	/ /			- -	/ /			
	/ /			- -	/ /			
	/ /			- -	/ /			

**COMPLETE FOR ELIGIBLE DEPENDENT(S)**

Employee's Name \_\_\_\_\_ Employee's Social Security # \_\_\_\_\_

ELIGIBILITY OR QUALIFYING EVENT CHANGE		LAST NAME	FIRST NAME	BIRTHDAY MO/DAY/YR	SEX	LIST NEW CHANGE (NAME/ADDRESS, ETC.)	COVERAGES AFFECTED
#	EFFECTIVE DATE						
	/ /			/ /			
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	/ /			/ /			

**COMMENTS:**

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EMPLOYER'S (OR REPRESENTATIVE'S) SIGNATURE \_\_\_\_\_

( ) - PHONE NUMBER \_\_\_\_\_

DATE \_\_\_\_\_

\*Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166. Dental HMO plans in CA, FL, and TX are available through a domestic company in the applicable state named SafeGuard Health Plans, Inc. The SafeGuard companies are part of the MetLife family of companies.