

Assurant Employee Benefits Member Change Submission

(This form is not intended to replace the Employee Application or to enroll a new employee.
Please use this form for changes, dependent removals or cancellations.)

Group Policy Number 5451578	Employer Harrisonburg City Public Schools	Effective Date
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Employee Name		
Last	First	M.I.

Personal Data Change

<input type="checkbox"/> Name Change	<input type="checkbox"/> Address Change
<input type="checkbox"/> Name Correction	<input type="checkbox"/> Phone Number Change
<input type="checkbox"/> Social Security Number Correction	

New Name - Last Name	First Name	M.I.
New Address - Street		Apt. #
City	State	Zip
New Phone Number (with area code)	Social Security Number Correction	

Membership Changes

Qualifying Event - Reason for Change

<input type="checkbox"/> Termination of Employment	<input type="checkbox"/> Switching from full to part time employment
<input type="checkbox"/> Change in employment - spouse	<input type="checkbox"/> Reduction in work hours
<input type="checkbox"/> Marriage Date _____	<input type="checkbox"/> Other - explain

Remove Dependent(s)

Spouse _____ Child/Children _____ Name(s) _____	
Remove All Dependents _____	
Cancel Coverage _____	Last Day of Coverage _____
<u>Employee Signature</u> _____	
<u>Date</u> _____	