Employee Name/Address/Benefits Change Form

Please return fax to: (334) 528-1351

Changes being made: Name _____ Address _____ Benefits _____

EMPLOYEE NAME: _____ EMPLOYEE NUMBER: _____

SOCIAL SECURITY NUMBER: _____ TELEPHONE #: _____

NAME CHANGE (NEW): _____ REASON: MARRIED OR DIVORCED

For name changes, provide a copy of the letter from the Social Security Office, OR a copy of your new SS Card

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DO YOU CURRENTLY HAVE INSURANCE WITH EAMC? ___ YES ___ NO
ARE YOU CURRENTLY ON SCHOLARSHIP? ___ YES ___ NO

By signing this form, you give EAMC permission to send a copy of the changes to the benefit providers checked. Please note that this does not change your name or address at the Credit Union, Business Office, or Accounts Payable.

CHECK TO DELETE THE FOLLOWING BENEFITS:

	EMPLOYEE	DEPENDENT(S)	EFFECTIVE DATE	ADDITIONAL FORMS
MEDICAL	_____	SPOUSE / CHILD	_____	_____
DENTAL	_____	SPOUSE / CHILD	_____	_____
VISION	_____	SPOUSE / CHILD	_____	_____
SUPPLEMENTAL LIFE	_____	SPOUSE / CHILD	_____	_____
SHORT TERM DISABILITY	_____		_____	LINCOLN
529 PLAN	_____		_____	_____

LIST ALL DEPENDENTS TO BE DELETED:

NAME:	SS#:	RELATIONSHIP:	DOB:	EFFECTIVE DATE:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

By signing this form, I acknowledge that I am aware that I am not eligible to re-enroll in this/these benefits until open enrollment OR within 30 days of a change in family status.

EMPLOYEE SIGNATURE: _____ **DATE:** _____