Employer's Resource Group, Inc.

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REQUEST FOR BENEFIT CHANGE

Employer/ Division: _____

Full Name: _____
Last First MI

Address: _____ **Phone:** ( ) _____
_____ ( ) _____

SS#: _____ **Birth Date:** _____ **Sex:** M F

PLEASE CHECK APPLICABLE CHANGE(S):

(___) **Address/Phone Change:** (My new address is above)
Former Address: _____

(___) **Name Change:** (My new name is above)
Former Name: _____
Reason for Change: ☐ marriage ☐ divorce ☐ legal name change
Please enclose copies of legal documentation (marriage license, court record for name change, etc.)

(___) **Add Dependent to Coverage**
This includes any status change such as marriage, divorce, birth, adoption, death, etc.
Complete the Add/Drop Section below.
Please enclose copies of legal documentation (marriage license, birth certificate, court order, etc.)

(___) **Drop Dependent Coverage**
This includes any status change such as divorce, birth, adoption, death, etc.
Complete the Add/Drop Section below.
Please enclose copies of legal documentation (divorce decree, death certificate, court order, etc.)

(___) **Cancel Insurance Coverage:** Medical Dental Life Other
REASON:

(___) **Add Insurance Coverage:** Medical Dental Life Other
REASON:

(___) **Change Beneficiary:** **Former:** _____ **Relationship:**
New: **Relationship:**

Cov Type	Section 125 Changes		Old Deduction			New Deduction		
EE	W BI SM M			EE	ER		EE	ER
E/S	Effective Date of Change:		MED			MED		
E/C			DEN			DEN		
F	Date of Payroll Change:		LIFE			LIFE		
			OTHER			OTHER		

ADD/DROP DEPENDENTS:

Name	Effective Date	Birth Date	Social Security Number	Sex

_____ _____
Employee Signature Date