BPA Benefit Plan Administrators Co.
Graham Riverside Building, 402 Graham Ave., P.O. Box 1128
Eau Claire, WI 54702-1128, (715) 832-5535 (800) 236-7789

EMPLOYEE CHANGE FORM

(Use separate Employee Enrollment Form to enroll new employee.)

EMPLOYER NAME	GROUP NUMBER	COVERAGE (Check all that apply) Medical Dental Disability Life Flex **(also need Flex form)**
		☐ ☐ ☐ ☐ ☐

EMPLOYEE LAST NAME	FIRST	MIDDLE	DATE OF BIRTH	SSN

CHECK AND COMPLETE CHANGES DESIRED:

☐ CHANGE NAME TO:

☐ ADDRESS CHANGE TO:

☐ DATE OF TERMINATION OF **COVERAGE:** (USUALLY THE LAST DAY OF THE MONTH)

Voluntary ☐ Involuntary ☐

☐ DATE CONTINUATION (COBRA) ELECTED:

☐ DATE DEPENDENTS ADDED/TERMINATED:

DATE OF MARRIAGE (if applicable):

SPOUSE - Last Name	First	Middle	Spouse's Date of Birth	SSN

OTHER DEPENDENTS:

First Name	MI	Last (if different)	Sex	Date of Birth	Relationship	SSN

** If there are more dependents, please list on the back of this form. **

Are any dependent children over 19? Yes ☐ No ☐ If yes, do they attend school full-time? Yes ☐ No ☐ Where?

OTHER COVERAGE: In addition to this coverage, will anyone named on this application be covered by any other insurance plans? (Y/N) ☐ Y ☐ N **(if YES, please complete the information below)**

Name of Person with Other Insurance: Effective Date:

Name of Other Insurance Company:

Type of Plan: ☐ Medical ☐ Single ☐ Family Covered Members

Type of Plan: ☐ Dental ☐ Single ☐ Family Covered Members

☐ DELETE DEPENDENT(S): EFFECTIVE (date) _____

(INDICATE "ALL" OR LIST INDIVIDUALS' NAMES) _____

☐ LOCATION CHANGE: FROM LOCATION # _____ TO LOCATION # _____

EFFECTIVE (date) _____

☐ PLAN CHANGE: FROM PLAN _____ TO PLAN _____

EFFECTIVE (date) _____

☐ DATE OF TEMPORARY LAY OFF: _____

☐ DATE RETURNED TO WORK FROM LAY OFF: _____

☐ DATE OF RETIREMENT _____

(IF NECESSARY, INDICATE CLASS CHANGE ABOVE)

OTHER COMMENTS: _____

EMPLOYEE SIGNATURE (OPTIONAL)

_____ DATE: _____

COMPLETED BY:

_____ DATE: _____

(Employer Authorized Signature)