

## EMPLOYEE CHANGE OF STATUS FORM

**To be completed by Employee**

**Instructions:**

1. Complete Section 1 and any other applicable section(s), sign and date. Mail or fax this form along with any necessary supporting documentation to the address or number listed above.
2. If you are changing your name, please enter your prior name in Section 1 and your new name in Section 2 along with the reason for the name change.
3. If you are enrolled in the DHMO plan and are using this form to change or select a network provider for yourself and/or currently enrolled dependents, you only need to complete Section 1 and fill in names and provider numbers in Section 3. Please note that provider changes must be received by the 20<sup>th</sup> of the month in order to become effective the first of the following month. Each family member may select their own dentist, orthodontist, and vision provider (up to 3 providers of each type per family).

**1. Employee Information**

Social Security/ID No.	Last Name	First Name	MI	Effective Date of Change / /
Name of Employer <b>Santa Barbara County-Self-Funded PPO</b>		Group No. <b>NP8059</b>	Business Phone / /	

**2. Change Name/Address/Phone**

New Name	Reason for Name Change <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Other _____	
New Street Address	City/State/Zip	New Phone No. / /

**3. Add/Delete Dependent Coverage or Change/Select DHMO Providers (If employee is enrolled in the DHMO plan)**

Add/Delete	Last Name	First Name	MI	Gender	Date of Birth MM/DD/YY	Dentist#	Ortho#	Vision #
	Self							
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Spouse/Domestic Partner			<input type="checkbox"/> Male <input type="checkbox"/> Female				
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Child			<input type="checkbox"/> Male <input type="checkbox"/> Female				
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Child			<input type="checkbox"/> Male <input type="checkbox"/> Female				
<input type="checkbox"/> Add <input type="checkbox"/> Delete	Child			<input type="checkbox"/> Male <input type="checkbox"/> Female				

If adding spouse or domestic partner, please give reason:  Marriage  Domestic Partner Registration  Court Order      Date of Event: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Birth/Adoption of Child  Loss of Other Coverage  Other (Please Explain) \_\_\_\_\_

If adding dependent child(ren), please give reason:  Marriage  Birth  Adoption  Court Order      Date of Event: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Other (Please Explain) \_\_\_\_\_

**Note: If dependent child is over the age of 19, a Dependent Verification Form will need to be completed and must accompany this form.**

If deleting dependent coverage, please give reason:  Divorce  Death  Coverage Elsewhere      Date of Event: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Other (Please Explain) \_\_\_\_\_

**4. Terminate Coverage While Actively Employed**

I am actively employed and eligible for benefits through my employer named in Section 1. I wish to terminate the following coverage(s). I understand that coverage for any enrolled dependents will terminate on the same date. I understand that if I wish to re-enroll at a later date, I may be subject to waiting periods and/or reduced benefits, or my coverage could be denied. **Note: Coverage will be terminated on the last day of the month in which a completed request to terminate coverage is received.**

Please terminate the following coverage(s): <input type="checkbox"/> Dental plan <input type="checkbox"/> Vision Plan 90GE or Vision Advantage	Reason for termination: <input type="checkbox"/> I am covered under my spouse's employer-sponsored plan <input type="checkbox"/> Other (please explain): _____
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X \_\_\_\_\_  
Signature of Employee Date (MM/DD/YY)