CHANGE OF STATUS FORM

GW PACESETTER

Employee Name (Please Print)		Social Security #
Last Name	First Name	☐☐☐-☐☐-☐☐☐☐
Group Name		**Group #**

1. Employee Name Change: Old Name ______________________ Last Name ______________________ First Name

Reason for Change ______________________ Date Change Occurred ____/____/____

2. Address and/or Telephone # Change:

New Street Address	Apt #	City	State	ZIP	New Home Phone #
					( )

3. Social Security Number Correction: ☐☐☐-☐☐-☐☐☐☐

4. Change Dental Office: New Office # ☐☐☐☐

Changes made by the 20th of the month will be effective the first of the following month.

5. Select Orthodontic Office: Office # ☐☐☐☐

Request for New ID Card ☐

6. Dependent Changes: Dependents to be insured: ☐ Spouse ☐ Spouse & Child(ren) ☐ Child(ren) ☐ None

Last Name	First Name	Add	Drop	Relationship	Date of Birth	Effective Date
					/ /	- -
					/ /	- -
					/ /	- -
					/ /	- -
					/ /	- -

If adding spouse due to marriage, what is the date of marriage?____/____/____

Was spouse covered for dental at his/her place of employment prior to this request? ☐ Yes ☐ No

If Yes, Give Reason for Loss of Coverage ______________________ **Date Coverage Stopped**____/____/____

If adding dependent child(ren), give reason: ☐ Birth ☐ Marriage ☐ Adoption ☐ Other ______________________

If dropping dependent coverage, give reason: ☐ Divorce ☐ Death ☐ Coverage Elsewhere ☐ Other ______________________

Date Event Occurred____/____/____

7. Terminate Coverage: Last Day of Employment____/____/____ Terminate Coverage On____/____/____

8. Reinstate Coverage: Effective Date____/____/____ Is Reinstatement Due to COBRA Election? ☐ Yes ☐ No (Provide dependent coverage in #6 above)

______________________ ____/____/____
Employee Signature (Do Not Print) Date Signed

______________________ ____/____/____
Benefit Manager Signature Date Signed

Golden West Office Use Only	
Requested by: ________	*Date:* ________
Entered by: ________	*Date:* ________

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