BENEFIT CHANGE FORM
KIER CONSTRUCTION CORP
GROUP NUMBER: SFKIR

TALL TREE ADMINISTRATORS

EMPLOYEE INFORMATION			
Name (Last, First, MI):			
SECTION 1 – CHANGE OF EMPLOYEE NAME OR ADDRESS			
Change Name From:	Change Address To:		
Employee's Name (Last, First, MI):	Employee Home Address:		
Change Name To:	City	State	Zip
Employee's Name (Last, First, MI):			

SECTION 2 – DROP COVERAGE

Drop coverage for myself and any dependents for the following checked boxes: ☐ Medical ☐ Dental/Vision

Effective Date: (Coverage will continue through the end of the month).

Qualified Event – State Reason for Cancellation:

SECTION 3 – ADD DEPENDENT(S)

Dependent(s) are being added to (check box that applies)

☐ As dependents acquired through birth, marriage, or legal adoption. (Attach copy of birth certificate, marriage license or adoption papers). Change form must be completed and submitted within 31 days from the Qualifying Event.

☐ Due to loss of eligibility under another Health Plan (name, group number and telephone number of the other Health Plan must be written on the back of this form). Change form must be completed and submitted within 31 days from the Qualifying Event.

☐ Open Enrollment

Dependent's Name: (Last, First, MI)	Gender	Relationship	Date of Birth	Social Security Number

SECTION 4 – DROP DEPENDENT(S)

☐ Because the person(s) listed no longer meet the requirements for being an eligible dependent under the plan, because of age, marriage, or divorce (please explain reason on the back of this form).

☐ Due to becoming eligible under another Health Plan (name, group number and telephone number of the other Health Plan must be written on the back of this form).

Dependent's Name: (Last, First, MI)	Gender	Relationship	Date of Birth	Social Security Number

Describe any other requested changes below:

SECTION 5 – CHANGE ELECTIONS				
	Single	**EE + Spouse**	**EE + Child(ren)**	**Family**
Medical/Dental/Vision				
Dental/Vision				

EMPLOYEE SIGNATURE	
I am requesting the changes documented on this form and authorize any required changes in payroll deductions.	
X	Date:

OFFICE USE ONLY		
Effective Date of Changes by Section #		
Section 1:	Section 2:	Section 3:
Section 4:	Section 5:	
Locations:		
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐

Employer Group Representative Signature	
X	Date: