CHRISTIAN BROTHERS SERVICES

Employee Benefit Trust
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Romeoville, IL 60446
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CHANGE OF DEPENDENT COVERAGE

PART 1- TO BE COMPLETED BY EMPLOYER.

Location Name:		Location #:	
Employee Name:			
Social Security Number:		**Date of Change**:	

PART 2- TO BE COMPLETED BY EMPLOYEE.

Change **or** Correct my Dependent Status to:
☐ No Dependent Coverage ☐ Spouse Only ☐ Child(ren) Only ☐ Decrease in the Number of Dependents

Reason for Change **and** effective date: (*please check one)*
☐ Divorce: ***Date of Divorce:***_____
☐ Terminating Dependent Coverage: ***Date:***_____
☐ Other_____
☐ Child Reaching Limited Age: ***Date:***_____
☐ Death: ***Date of Death:***_____

Dependents: (Information needed to meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Last Name:		First Name:		SS#:	
Last Name:		First Name:		SS#:	
Last Name:		First Name:		SS#:	
Last Name:		First Name:		SS#:	
Last Name:		First Name:		SS#:	

PART 3- ELECTION OF CONTINUED OPTIONAL BENEFITS (TO BE COMPLETED BY EMPLOYEE)

Name of Person Continuing Coverage:		Relationship to Employee:	
Social Security Number:		Date of Birth:	
Continuing Person's Home Address:			

PLEASE READ CAREFULLY AND COMPLETE SECTION BELOW IF CONTINUING COVERAGE.

A dependent who is no longer eligible as defined in "Your Employee Benefits" booklet can continue optional benefits in force at the time of ineligibility for up to 18 months. Coverage cannot be continued if the dependent is covered under another group plan, or if the person is eligible for Medicare. ***The maximum continuation period in any case would be 18 months, starting the first month following the date of ineligibility. A dependent must have been enrolled for group coverage for at least three months to be eligible for the extension.*** Coverage cannot be continued if the proper contributions are not made or if the group plan terminates.

Please note: Dependents under age 18 are not eligible to continue coverage unless the parent/legal guardian is also eligible to continue coverage. Please continue coverage for:
☐ Spouse ☐ Spouse and Children ☐ Child(ren)

Note: You must advise, *in writing*, in the event you are no longer eligible for continuation or you no longer want to continue your optional benefits. I certify that I am not covered under any other insurance plan at this time, nor eligible for Medicare.

Name of Person Making Election (please print):		Date:	
Signature of Person Making Election:			