



# REMIF CHANGE FORM

**ENTITY NAME:** \_\_\_\_\_

**REASON FOR CHANGE**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Name Change      | <input type="checkbox"/> New Address    | <input type="checkbox"/> Class/Benefit Change |
| <input type="checkbox"/> Salary Change    | <input type="checkbox"/> Add Dependents | <input type="checkbox"/> Drop Dependents      |
| <input type="checkbox"/> Retiree Coverage |   |   |
| <input type="checkbox"/> Other: _____     |   |   |

**A. SUBSCRIBER INFORMATION. Name is required; fill in other applicable information only if changing.**

**Subscriber Name is Required:**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **M.I.:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female Marital Status:  Single  Married  DP

Social Security Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
 Check if new

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**B. REQUESTED CHANGES. Complete only areas that are changing.**

Effective date of change: \_\_\_\_\_ Reason for change: (newborn, marriage, divorce) \_\_\_\_\_

Add Dental  Drop Dental  Add VSP  Drop VSP  SALARY CHANGE: \_\_\_\_\_  
 New **Annual** Salary

Job Title Change: \_\_\_\_\_  
 New Title

Name Change from \_\_\_\_\_ to \_\_\_\_\_

Life/AD&D Class change from \_\_\_\_\_ to \_\_\_\_\_  New Life/AD&D Volume \_\_\_\_\_  LTD Class change from \_\_\_\_\_ to \_\_\_\_\_

Add or  Drop Voluntary Benefits:  Vol. Employee Life  Vol. Spouse Life  Vol. Child Life  Vol. LTD  
 Please note: adding voluntary benefits may require separate carrier form(s)

Reason for add/drop: (newborn, marriage, divorce, no longer wants) \_\_\_\_\_

**C. List ONLY Members who are Adding/Dropping/Changing (Attach additional sheets if necessary) – No need to fill in shaded areas.**

Add/Delete	Last Name	First Name	MI	Relation	Social Security Number	Date of Birth	Gender	Check Coverage(s) Elected
	Employee Name			Self				<input type="checkbox"/> Dental <input type="checkbox"/> Basic Life/ADD <input type="checkbox"/> Vision <input type="checkbox"/> LTD <input type="checkbox"/> EAP <input type="checkbox"/> STD <input type="checkbox"/> Vol. Benefits
	Spouse/Domestic Partner			<input type="checkbox"/> Spouse <input type="checkbox"/> DP				<input type="checkbox"/> Dental <input type="checkbox"/> Basic Life/ADD <input type="checkbox"/> Vision <input type="checkbox"/> LTD <input type="checkbox"/> EAP <input type="checkbox"/> STD <input type="checkbox"/> Vol. Benefits
	Dependent							<input type="checkbox"/> Dental <input type="checkbox"/> Basic Life/ADD <input type="checkbox"/> Vision <input type="checkbox"/> LTD <input type="checkbox"/> EAP <input type="checkbox"/> STD <input type="checkbox"/> Vol. Benefits
	Dependent							<input type="checkbox"/> Dental <input type="checkbox"/> Basic Life/ADD <input type="checkbox"/> Vision <input type="checkbox"/> LTD <input type="checkbox"/> EAP <input type="checkbox"/> STD <input type="checkbox"/> Vol. Benefits
	Dependent							<input type="checkbox"/> Dental <input type="checkbox"/> Basic Life/ADD <input type="checkbox"/> Vision <input type="checkbox"/> LTD <input type="checkbox"/> EAP <input type="checkbox"/> STD <input type="checkbox"/> Vol. Benefits

**Employee Signature Required** \_\_\_\_\_ **Date** \_\_\_\_\_