



Change of Status Form

Employee Name – Last	First	Middle	SS#	
Home Address	City		State	Zip
Name of Firm Where Employed				

EMPLOYEE CHANGE OF NAME

New Name – Last	First	Middle
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If the name change is due to marriage and you do not wish to cover your eligible dependent(s), please complete a Refusal Form

ADDITION OF DEPENDENT(S)

If adding a spouse, enter date of marriage:	Mo.	Day	Year	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
Dependent Name	Relationship	Sex	Date of Birth	Social Security Number	

Check here if dependent added was previously covered as an employee

TERMINATION OF DEPENDENT(S)

Requested Date:	Mo.	Day	Year	of Termination	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
Specify Termination			Reason			
<input type="checkbox"/> Terminate all Dependents <input type="checkbox"/> Termination of Employment Last day of Employment _____ <input type="checkbox"/> Other – Describe Below _____ _____ _____			<input type="checkbox"/> Death <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Other _____ Specify Other Reason _____			
Name of Dependent(s)						

Check here if dependent terminated will be enrolling as an employee with this employer.

Your Signature in ink	Date Signed
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OFFICE USE ONLY

Processed by.	Process Date		Eff. Date of Change
Dental Grp.#	Dental Code	Vision Grp.#	Vision Code

v.2010/01/01

Administered by:
 PacFed Benefit Administrators, Inc.
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