## HEALTH CARE EMPLOYEE BENEFITS CHANGE REQUEST FORM

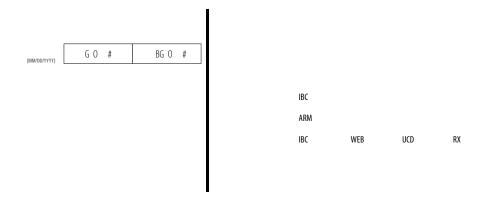
## **EMPLOYEE INSTRUCTIONS:**

This form is to be completed only when a change needs to be made for an existing employee. Do not complete this form to add a new employee; an enrollment application must be completed for this purpose. This form may be completed by the employee, but must be signed by the employer before it is sent to Advenyor an example by the employee.

CHANGE DETAILS: (Fill in details for above marked choice)

Middle INITIAL: DATE OF BIRTH: SSN#

| CHILDREN INFORMATION |      |         |          |  |              |              |
|----------------------|------|---------|----------|--|--------------|--------------|
| FI NAME              | M.I. | LA NAME | BI HDA E |  | DE ENDAN 'N# | O HE IN ANCE |



EMPLOYER SIGNATURE\*:

DATE (MM/DD/YYYY):

SIGNATORY'S NAME: COVERAGE CODE:

SIGNATORY'S TITLE:

By entering your initials and sending this form attached to an e-mail from your e-mail account, we will consider this form signed by you.

<sup>\*</sup>Please enter your initials to serve as your digital signature.