



HEALTH ENROLLMENT CHANGE FORM

Michigan Tech employees who have healthcare coverage **are required** to contact the Benefits Office within 30 days with any family status change.

New Employee COBRA Change (complete change section) Hire Date: _____

Employee Name: _____ Social Security #: _____

Street: _____ City: _____ State: _____

Zip: _____ Phone: _____ Birthdate: _____ Marital Status: _____ Sex: _____

CHANGE SECTION: (Please select the appropriate change and indicate new information)

Effective Date of Change: _____ Reason for Change: _____

Add Dependents: (see below)

Employee Name Change: _____

Employee Address Change: _____

Date of Marriage: _____ Date of Divorce: _____

Remove Dependents: _____

Reason: _____

Dependent's Address: _____

FSA Enrollment: Complete this section only if you want to enroll in FSA due to a family status change

Flexible Spending Health Care \$ _____ Contribution per pay period \$ _____ Annual Contribution

Flexible Spending Dependent Care \$ _____ Contribution per pay period \$ _____ Annual Contribution

	Name	Birth Date	F / M	
Spouse:				
Child:				

I hereby certify that all of the above information is true and correct. I understand that group coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved by the plan sponsor.

Employee Signature: _____ Date: _____

Notice: Your coverage is provided by your employer on a self-funded basis. Benefits are funded by your employer and administrative services are provided by Aetna.

Benefits Office Use: PDAEDN PDABENE AETNA PZABCOV