Snohomish County Human Resources

Benefits Change Form

The Benefits Change Form is ***NOT AN ENROLLMENT FORM****. If you wish to enroll in a new benefit plan, you must complete the designated enrollment form. It is the employee's responsibility to coordinate any name or address changes with the AFLAC and/or Nationwide representative.*

Coverage begins on the effective date when HR receives this form. If eligibility documents are not received within alotted time, requested coverage will stop and further coverage will be denied until the next open enrollment unless HR is notified as to when documents will be available.

PLEASE COMPLETE ALL SECTIONS THAT APPLY:

Name:		**Home Phone:**	
SSN:		**Department:**	
Work Phone:	**EXT:**	**Effective Date:**	(HR Use Only)

REASON FOR CHANGE: _

☐ **New address**	
☐ **Name change**	Previous Name / New Name

A copy of an updated Social Security Card is required for a Name change

☐ **Add dependent(s)**

Please select a Qualifying Event to add a dependent outside of the Open Enrollment period. In order for Snohomish County to provide coverage for dependents, we must confirm their relationship to you. Copies of Certified government legal documents are required for marriages, births, and adoptions. ***If documents are not received within the alloted time, coverage will cease.***

- ☐ **Marriage** – attach certified marriage certificate **Date:**
- ☐ **Domestic partnership** – attach Affidavit of Domestic Partnership
- ☐ **Birth of child** – attach birth certificate **Date:**
- ☐ **Adoption of child** – attach Adoption Decree **Date:**
- ☐ **Legal guardianship** – attach court order **Date:**
- ☐ **Job loss** **) ate:**
- ☐ **Other:**

☐ **Remove dependent(s)**

- ☐ **Remove spouse –** Indicate date of divorce, if applicable:
- ☐ **Remove domestic partner**

INFORMATION:)

Add	Del	Name	Relationship	SSN	Birth Date	M/F
☐	☐					
☐	☐					
☐	☐					

MEDICAL FOR: ***SHERIFF DEPUTY, SERGEANTS, CAPTAINS & LIEUTENANTS and FIRE FIGHTERS:***

REGENCE 10008695	PLAN	TRADITIONAL 10008695	PLAN	GROUP HEALTH 6177000
☐ Select 10	0003	☐ Traditional Plan	0002	☐ Group Health
		For Changes Only ***NO ENROLLMENT***		

MEDICAL FOR: u- ˚ U ou-koO ‡ -V7\ k#-U -Vu oyhh\ ku #\ kk-#u@ V oyhh\ ku #\ kk-#u@ V 8y@)
CORRECTION SUPERVISORS; CORRECTIONS SERGEANTS, LIEUTENANTS & WRS (Captains & Sergeants)
k-8-V#- 8k\ yh VyU " -k 7\ k OOhO Vo

☐ **REGENCE** o-O #u	☐ **REGENCE PPO** o-O #u	☐ **GROUP HEALTH 6097300**

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☐ **PLAN** ˚	☐ **hOAN** "	☐ **GROUP HEALTH 6097300**
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PREVIOUS COVERAGE & COORDINATION OF BENEFITS:

- If you and/or your dependents were covered by a non-County insurance provider (medical, dental, vision) *within the last 3 months*, please indicate the insurer and the dates of coverage: __________From:________To:________
- If you and/or your dependents are *currently* insured by a non-County insurance provider (medical, dental, vision) please indicate the insurance information below for coordination of benefits:

Name of Policy Holder:	SS#	DOB	Insurance Company Name	Policy Number(s)
			From:	To:
Employer of Insured			Date Coverage Began	Date Coverage Ended

EMPLOYEE SIGNATURE: __________ **DATE:** ______ **HR INITIALS:** ____

For Use by Human Resources Only

IBEL ☐	IBEN ☐	IECT ☐	IBRA ☐	IPSN ☐	IEID ☐	UDF ☐	IEPI ☐	COBRA ☐	DATE MAILED:

Revised 3/19/2012