

Administrative Services Only Dental Change Request



ASSURANT Employee Benefits

Plan number _____ Date _____

Employer name _____ Telephone number _____

1. EMPLOYEE TERMINATION OF EMPLOYMENT

Employee SSN	Employee Name	Reason for Termination	Last Day Worked			Continuation Elected	COBRA Election Form Attached
			Mo	Day	Yr		

2. EMPLOYEE CHANGE OF NAME (Please print or type.)

Old name _____ Effective date _____

New name _____ Employee Social Security no. _____

Reason: Married Divorced Other _____

3. NEW ADDRESS

Employee name _____ Employee Social Security no. _____

Street address _____ City, state, zip code _____

4. REQUEST FOR COVERAGE STATUS CHANGE

Employee name _____ Effective date _____

Employee Social Security no. _____

Add

Dependent name	Relationship	Date of Birth	
_____	_____	_____	If spouse being added due to marriage, date of marriage _____
_____	_____	_____	
_____	_____	_____	

***Delete:** Spouse Date of death or divorce _____ Children only All dependents

*Waiver (below) **must** be completed and signed by the employee for deletions.

5. WAIVER OF DENTAL COVERAGE (Please print or type.)

Effective _____, I _____ Social Security no. _____, wish to waive the following benefits to which I am eligible:

	Dental
Myself	
My spouse	
My child(ren)	

Because: Covered by spouse's employer Other (Explain.) _____

Name of spouse's employer _____ Name of spouse's insurance company _____

EMPLOYEE SIGNATURE

DATE

EMPLOYER/ADMINISTRATOR SIGNATURE

DATE

Products and services marketed by Assurant Employee Benefits are underwritten and/or provided by Union Security Insurance Company.