



# BENEFIT CHANGE FORM

City of Gulfport  
 1410 24<sup>th</sup> Avenue  
 Gulfport, MS 39501  
 228.868.5831 Office  
 228.868.5833 Fax

**This form is NOT to be used for any COBRA event.  
 Use Benefit Termination Notice instead.**

GROUP NAME City of Gulfport			GROUP NUMBER Plan # <b>10609</b>
EMPLOYEES LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER

<p>(1) <input type="checkbox"/> APPLICATION FOR ADDITION OF DEPENDENTS</p> <p>(2) <input type="checkbox"/> DELETION OF EMPLOYEE COVERAGE</p> <p>(3) <input type="checkbox"/> DELETION OF DEPENDENT COVERAGE: <b>Must have qualifying event and provide documentation, unless deletion is done during open enrollment.</b></p> <p>Please list dependents after checking this box.        Check appropriate Coverage box for each dependent.</p>	<p>EFFECTIVE DATE OF ADDITION/DELETION: _____</p> <p style="text-align: center;"><b>CIRCLE TYPE OF EVENT</b></p> <p>(A) For eligible spouse – give date of marriage</p> <p>(B) For adopted child – give date of legal adoption or date appointed guardian – Attach copy of adoption or guardianship papers.</p> <p>(C) For child acquired by marriage – give date of marriage.</p> <p>(D) For birth of child – give date of birth and certificate of live birth (must be provided within 31 days of birth).</p> <p>(E) For loss of Job/Coverage – give date of loss of job- Provide Certificate of Insurance</p>
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**EMPLOYEE AND/OR DEPENDENT INFORMATION**  
 COMPLETE FOR YOURSELF AND EACH DEPENDENT TO BE COVERED BY THE PLAN

FULL NAME	SEX		DATE OF BIRTH			SOCIAL SECURITY NUMBER	COVERAGE REQUESTED
	M/F		MO	DAY	YEAR		
EMPLOYEE							<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1000 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision
SPOUSE							<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1000 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision
CHILDREN							<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1000 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision
1.							<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1000 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision
2.							<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1000 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision
3.							<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1000 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision
4.							<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1000 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision
5.							<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1000 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision
6.							<input type="checkbox"/> Medical Only <input type="checkbox"/> Dental 1000 <input type="checkbox"/> Dental 2000 <input type="checkbox"/> Vision

(4) <input type="checkbox"/> CHANGE OF NAME: (must provide copy of social security card)	FROM:	TO:	
(5) <input type="checkbox"/> CHANGE OF ADDRESS:	FROM:	TO:	
(6) <input type="checkbox"/> TRANSFER TO NEW DIVISION:	FROM:	TO:	
(7) <input type="checkbox"/> OTHER CHANGE TO RECORD:	FROM:	TO:	

Employee Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Personnel Use Only

Entered By: \_\_\_\_\_ Date Entered into Benefits Portal: \_\_\_\_\_