

Employee Change Form – Section 125

Administered By: GETTYSBURG HEALTH ADMINISTRATORS

404 Baltimore Street, P.O. Box 1060 Gettysburg, PA 17325-1060

Boxes 1 thru 8 MUST be completed. Please press firmly and use a ball point pen.

1) Employee's Last Name, First Name, M.I. :	2) Social Security # / Agreement #:
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3) Employee's Address:

4) Company/ Group Name :	5) Group ID #:
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6) Please make the following changes to my Agreement effective (month & day):
IMPORTANT: If the employee has terminated employment, this date must be their last day of employment _____/_____/20____

7) Please make the following changes effective to the following coverages:
 MERP/HRA (Medical Expense Reimbursement Program / Health Reimbursement Arrangement)
 HCR FSA (Health Care Reimbursement FSA)
 DCR FSA (Dependent Care Reimbursement FSA)

8) Employee Signature (if employee is not available for signature, the corresponding person needs to write: "Not available for signature." The correspondent then signs his/her own signature).
 X _____ **Date:** ____/____/____

A. NAME CHANGE: From: _____ **To:** _____

<input type="checkbox"/> B. CHANGE OF HOME ADDRESS TO:	City	State	Zip
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C. CHANGE PHONE # TO: () -

D. ADD DEPENDENTS – Enroll the dependents listed below.:

First Name, MI (Last Name, if different from Employee's)	RELATIONSHIP (spouse; child)	Birthdate	Sex	Social Security #	Medicare or RR Retiree ID	Fulltime Student *

*Attach completed Student Verification Form for each unmarried child, age 19 or over, who is fulltime student in an accredited school.

Reason for Addition: (For Spouse, include date of marriage, For adopted child, include a copy of adoption papers)

Other Coverage Information (Complete when adding dependents to your Agreement.)

Place a check next to all who are now covered by other Group Health Insurance. Myself My Spouse My dependent children None

Name of Insurance Carrier:	Name of Group:	Coverage issued to: <input type="checkbox"/> Me <input type="checkbox"/> My spouse <input type="checkbox"/> Other	Effective date	Spouse's DOB
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E. CANCEL EMPLOYEE COVERAGE. Give Reason for Cancellation:

F. CANCEL BENEFITS FOR THE ENROLLED DEPENDENTS LISTED BELOW:

First Name, MI (Last Name, if different from Employee's)	RELATIONSHIP (spouse; child)	Birthdate	Sex	Reason for Cancellation

G. COBRA ELECTION – effective date ____/____/____ **Termination Date:** ____/____/____ **NOTE THIS IS TO ENROLL IN COBRA ONLY!**
 1. EE only EE and Dependents Dependents only 2. Core Coverage Only Core coverage and Non-Core Coverage

H. CHANGE ELECTION AMOUNT DUE TO QUALIFYING EVENT:
 HCR FSA NEW ELECTION: \$ _____ DCR FSA NEW ELECTION: \$ _____

For Office Use Only: Approved _____ By: _____ Effective Date of Change: _____ Notes: _____