

Employee Request to Request to Change Status

MULZERCRUSHED STONE, INC.

Administered By:

BENEFIT SYSTEMS, INC.
P.O. Box 6001
Indianapolis, IN 46206-6001
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EMPLOYEE INFORMATION

Employee Last Name	First	Middle	Social Security Number	
Employer Class	Group Number		Branch Code	Benefit
MULZER CRUSHED STONE, INC.		10001		

CHANGE(S) DESIRED

NAME CHANGE
 Employee From _____ To: _____
 Dependent From _____ To: _____
 ADDRESS CHANGE
 New Address _____
 City, State, Zip _____

Addition of Dependent(s): (Federal law requires that we obtain the Social Security Number for each covered dependent. Failure to comply may delay your enrollment.)

NAME	Last	First	MI	BIRTHDATE	SEX	SOCIAL SECURITY #	RELATIONSHIP	Does this child reside with you	% of support you provide
Spouse	_____	_____	_____	_____	_____	_____	_____	_____	_____
Child	1	_____	_____	_____	_____	_____	_____	_____	_____
	2	_____	_____	_____	_____	_____	_____	_____	_____
	3	_____	_____	_____	_____	_____	_____	_____	_____

Reason for addition:

Loss of other coverage - proof required
 Newborn
 Marriage - provide dates: _____
 Other - provide details: _____

Special Enrollment will be available if the Employee completes the enrollment process within 30 days following the loss of other coverage. Dependent Special Enrollment will be available if the Employee completes the enrollment process within 30 days following the qualifying event. Please note: If you do not enroll within 30 days after becoming eligible, you will be ineligible for future enrollment unless the Employee qualifies for Special Enrollment under the current HIPAA provisions.

Deletion of Dependent(s):
 1. _____ Social Security # _____ Date of Birth _____
 2. _____ Social Security # _____ Date of Birth _____
 3. _____ Social Security # _____ Date of Birth _____

Reason for deletion:

Divorce - provide date: _____
 Dependent is not eligible (check one):
 Not a full-time student as of: _____
 Reached maximum age for coverage
 Other - provide details: _____

Add the following coverage(s) as applicable under my plan subject to current HIPAA provisions:

Coverage	Employee	Spouse	Child(ren)	Spouse & Children
Weekly Disability	_____	_____	_____	_____
Medical	_____	_____	_____	_____
Dental	_____	_____	_____	_____

(71 Delete the following coverage(s): Effective:

Coverage	Employee	Spouse	Child(ren)	Spouse & Children
Weekly Disability	_____	_____	_____	_____
Medical	_____	_____	_____	_____
Dental	_____	_____	_____	_____

Signature of Employee _____ Date _____

TO BE COMPLETED BY EMPLOYER

Is Employee Still Employed Yes No If No, Term Date _____
Employer Signature _____

Date Information Submitted to BSI _____ Office Use Only
BSI Representative _____ Action Taken _____ Effective Date of Change _____