EMPLOYEE CHANGE/TERMINATION FORM

Mail Completed Form to: Significa Benefit Services Inc., P. O. Box 7777, Lancaster, Pennsylvania 17604-7777
Tel: 717-581-1300 or 800-433-3746 or email to: poladmin@significabenefits.com

Employer: Keep a copy for your records and provide a copy to the employee

A. Box 1 through 5 MUST be completed for all changes and/or terminations.

1) Employee's Last Name, First Name, Middle Initial:	2) Social Security Number (Member ID):
3) Home Address: ❒ Check if New Address	State: Zip: Home Phone Number:
4) Email Address:	
5) Company/Employer Name:	6) Group #:

B. Name Change From: To:

C. Beneficiary Change In accordance with the group plan, the employee revokes the previous Beneficiary designation and chooses the following to receive benefits in the event of death.

Primary Beneficiary:	Name:	Relationship:
Contingent Beneficiary: (if no Primary Beneficiary is living)	Name:	Relationship:

D. Coverage Waiver **IMPORTANT**: The employee understands that if coverage is voluntarily waived and is applied for at a later date, he and his dependents may be treated as "Late" enrollee(s) under the terms of the plan. **EMPLOYER**: Any mid-year status changes that are made outside of the plan's open enrollment period must conform to applicable Section 125 and plan document requirements.

The employee understands he/she is eligible for group coverage and has decided voluntarily not to elect coverage for:

❒ Employee ❒ Dependents ❒ Employee and Dependents ❒ Spouse Only ❒ _____

Type of Coverage Decline _____ Reason _____

Is spouse insured through another employer: ❒ Yes ❒ No

Name of Insurance Company _____

If "Yes" Employer Name _____

Policy # _____

Employee Signature:

Sections E and F are to be completed by the Employer only.

E. Employee Status Change Effective Date of Change: (Mo/Day/Yr) _____/_____/_____

☐ Class or Position Change	The employee is now in the following new class or position:
☐ Salary Change	The employee's salary changed to: _____ per ❒ Hour ❒ Week ❒ Month ❒ Year
☐ Reinstatement	Reinstate coverage for employee – Reason _____(if applicable, rehire date ___/___/___)
☐ FMLA Leave	Begin Date _____ Expected Return Date _____ (12 week maximum)

F. Termination Notice Reason for Termination:

Last Day Worked (Mo/Day/Yr) _____/_____/_____

Important: All claims prior to the termination date must be submitted within 90 days after employment ends. Please be aware that your coverage has terminated in accordance with the terms of the group plan on the above date.

Employer Authorized Signature _____
Date_____
(applies to all changes above)