

DENTAL INSURANCE CHANGE REPORTING FORM

Employer: General Synod, ARP Church

Plan Number: GAR0801

Employee Name: _____

Employee's SSN: _____

A. **Items 1 through 3 require an employee's signature and date.** Return the completed form to Board of Benefits, 1 Cleveland Street, Suite 110, Greenville, SC 29601-3696

- 1. Change name to: _____
- 2. Change Dependent Coverage:
 - Add Family Coverage (List Dependents)
 - Delete Family Coverage (List Dependents)
 - Add Dependent (List Dependent)
 - Delete Dependent (List Dependent)
 - Change to Employee Plus 1
- 3. Terminate Dental Coverage.

Effective Date of Change: _____

Reason for Change: _____

<u>Name</u>	<u>Relationship</u>	<u>DOB</u>	<u>Social Security Number</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

NOTE: If family coverage is in effect, all new dependents will be automatically covered under this Plan on the date they became eligible. However, you must submit name and DOB.

Signature of Witness for Item 1

Signature of Covered Person/Date

B. To be completed by Plan Administrator:

- Change coverage classification to COBRA-Type Coverage
Effective date of change: _____ COBRA paid through _____
- Terminate all coverage effective _____
- Reinstatement coverage: Date left work: _____ Date returned to work: _____

Additional Comments:

Employer's Representative/Date