METLIFE CHANGE REQUEST



GROUP NAME:					GROUP NUMBER:					
RST NAME:		MI:_	LAST NAME	:EID:						
DDRESS:		CITY: _				ST:	PHONE NUMBER:			
TYPE OF ELIGIE	BILITY CHANGE: (Ple	ase list below)					QUALIFYING E	VENTS:	DATE:	
	Name Change Address Change	6. Partial Cancellation (List Coverages to be Cancelled)					Q1. Add Dependent – Marriage Q2. Add Dependent(s) – Birth or Adoption Q3. Add Dependent(s) – Loss of Coverage		<u> </u>	
	3. Cancel Spouse	7. Cancel All Coverage - Termination of Employment				Q2. Add Dependent(s) – Birth or Adoption Q3. Add Dependent(s) – Loss of Coverage Q4. Death Q5. Rehired Employee Q6. Divorce 1 1				
	4. Cancel 1 Child	8. Cancel All Contributory Coverage - Request of Active Employee								
	5. Cancel All Children	9. Other				** Proof of loss is required with submission				
necessary informa	tion must be included to a									
		CO	MPLETE FOR E	LIGIBLE EI	MPLOY	EE(S)				
ELIGIBILITY OR QUALIFYING EVENT CHANGE # EFFECTIVE DATE	LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER	BIRTHDAY MO/DAY/YR	SEX		NEW CHANGE Y/ADDRESS, ETC.)	COVERAGES AFFECTED		
1 1				1 1						
1 1				1 1						
1 1				1 1						
1 1				1 1						
		COI	MPLETE FOR E	LIGIBLE DE	PENDE	NT(S)				
imployee's Nam	e			Employee	e's Socia	al Security	#			
ELIGIBILITY OR UALIFYING EVENT CHANGE	LAST NAME	FIRST NAME		BIRTHDAY MO/DAY/YR	SEX	LIST NEW CHANGE (NAME/ADDRESS, ETC.)		COVERAGES AFFECTED		
# EFFECTIVE DATE										
1 1				1 1						
1 1				1 1						
1 1				1 1						
1 1				1 1						
OMMENTS:				1 1						
PLOYEE'S (OR REP	RESENTATIVE'S) SIGNAT	URE	<u>() -</u> PHONE NUMBI	ER	DATE					

CHANGE REQUEST FORM (08/21)