

Benefit Change Form – Plan Year 10/01/07 - 09/30/08

Last Name:

First Name:

Worksite Employer:

HOSPITAL INDEMNITY COVERAGE:

Add employee and/or dependents to plan

Dependent changes; Add, drop, etc.

Drop employee and all dependents from coverage

Please contact Merit Resources and request the form

SHORT TERM DISABILITY INSURANCE: (pre-existing conditions do apply)

Add or change plan

Select coverage level to the right:

Maximum Weekly Benefit

Fixed Dollar Weekly Benefit \$ _____

Drop coverage

ENHANCED LONG TERM DISABILITY INSURANCE: (all requests are subject to medical underwriting)

Add or change plan

Please contact Merit Resources and request the form

Drop coverage

SUPPLEMENTAL LIFE INSURANCE: (all requests are subject to medical underwriting)

Add employee and/or dependents to plan

Dependent changes; Add, drop, etc.

Drop employee and all dependents from coverage

Please contact Merit Resources and request the form

Dependent info:

Last name

First Name

Date of Birth

1

Social Security Number

Gender

Relationship to employee

- -

Add to Medical

Drop from Medical

Add to Dental

Drop from Dental

Add to Vision

Drop from Vision

Last name

First Name

Date of Birth

2

Social Security Number

Gender

Relationship to employee

- -

Add to Medical

Drop from Medical

Add to Dental

Drop from Dental

Add to Vision

Drop from Vision

Last name

First Name

Date of Birth

3

Social Security Number

Gender

Relationship to employee

- -

Add to Medical

Drop from Medical

Add to Dental

Drop from Dental

Add to Vision

Drop from Vision

Last name

First Name

Date of Birth

4

Social Security Number

Gender

Relationship to employee

- -

Add to Medical

Drop from Medical

Add to Dental

Drop from Dental

Add to Vision

Drop from Vision