CHANGE IN STATUS/RENEFICIARY/NAME

True Name True									CHANGE	114 017100	/DENEFICIAL		
In order to process your request, this form must be deted and signed. STATUS CHANGE REQUEST Single to Family Family to Single No Change Ni to Single Ni to Family Single to Family Single to Family Personal to the Change Ni to Single Ni to Family Ni to Fa		Group #	Division	Class	Certificate #	Name o	of Employer						
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Fly ou and/or your dependents are electing to waive health and/or dental coverage, please complete the opt-out section below. CHANGE DUE TO: Marriage (tate of marriage)		In order to	proces	s your	request, this	form mu	st be dated	and s	igned.				
CHANGE DUE TO: Separation (date of marriage) Complete dependent information below Seth of Child - complete dependent information below Seth of Child - complete dependent information below Seth of Child - complete dependent information below Separation (date of separation) Are children still to be covered under your policy? Yes No. Are you good properties and your policy? Yes No. Are you good properties and your policy? Yes No. Are you good properties and you good provide these benefits of Yes No. Are you good provide these benefits Yes No. Are you good provide these benefits Yes No. Are you good provide dependent information below Separation (date of disorce) Are children at all to be covered under your policy? Yes No. Are you legally deligated to provide these benefits Yes No. Are you legally obligated to provide these benefits Yes No. Are you legally obligated to provide these benefits Yes No. Are you legally obligated to provide these benefits Yes No. Are you legally obligated to provide these benefits Yes No. Are you legally obligated to provide these benefits Yes No. Are you legally obligated to provide these benefits Yes No. Are you legally obligated to provide these benefits Yes No. Are you legally obligated to provide these benefits Yes No. Are you legally obligated to provide these benefits Yes No. Are you legally obligated to provide these benefits Yes No. Are you legally obligated to your poll of death) No. Single to Employee Separation	STATUS CHA	NGE REC	QUEST	. \square	Single to Fami	ly 🔲 I	Family to Sir	ngle	☐ No Change	☐ Nil to Singl	e	y	
Marriage (date of marriage)	* If you and/or your	dependents	are ele	cting to	waive health a	nd/or der	ntal coverage	e, plea	ise complete the op	ot-out section below	w.		
complete dependent information below	CHANGE DUE TO	:											
Birth of Child - complete dependent information below Sarpouse as spill to be covered under your policy? See No No See No No See No No See No No No See No No No No No No No													
Settind clid complete dependent information below Septing of Children Common-law spouse (date or-habitation began) If yes, please provide copy of legal agreement or court order complete dependent information below Septing of Ministry Septing of Children all to be covered under your policy? Yes No No No No No No No N	complete dependent information below												
Discrete (date of discrete)	☐ Birth of Child - complete dependent information below								Are you legally obligated to provide these benefits? ☐ Yes ☐ No				
Children of Common-law Spouse Sepouse still to be covered under your policy? Yes No No No Detect hidren reside with you? Yes No No Detect hidren reside with you? Yes No No Detect hidren reside with you? Yes No No Detect hidren reside with you? Yes No No Detect hidren reside with your plan your persons of the person of proverage - spousal coverage in place. Previous Insurance Carrier Previous Insurance Insura									ivorce (date of dive	orce)			
List all eligible dependents below. Do the children reside with you? Yes No Pesh Pes	Children of Common Jour Secure												
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APPLICABLE BENEFITS:	PREVIOUSLY	WAIVED	BENE	FITS									
My comparable coverage terminated on												w.	
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Authorization: Lunderstand the information L provide on this form will be used by PWAM Incurance Administrators Inc (PWAM) and the incurar for the purposes of													
determining eligibility for group insurance coverage and benefits; and to administer benefits under this coverage. I hereby authorize my employer/plan administrator, the authorized group agent/broker, and the insurer to exchange any relevant and necessary information for such purposes. If I am applying for coverage for my eligible dependents, I confirm I am authorized to act on their behalf for such purposes. I declare that the statements made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided. This authorization will remain valid for as long as I am claiming benefits or service, or until revoked by me.	determining eligik authorized group dependents, I cor	oility for grou agent/broke ofirm I am aut	p insuran r, and th horized to	ice cove e insur o act on	erage and benef er to exchange their behalf for	fits; and to any relev such purpo	administer land necesses. I declar	benefit essary e that	s under this coverage information for sucting the statements made	ge. I hereby authorize the purposes. If I ame on this form are continuous to the continuous transfer and the continuous transfer are continuous transfer and the continuous transfer are continuous tr	ze my employer/plan a applying for coverage mplete and true. I unde	dministrator, the e for my eligible rstand that if any	

Employee's Signature X ______ Date _____