COCHISE COMBINED TRUST **COCHISE COUNTY** **QUALIFYING EVENT CHANGE FORM ONLY**

AMERIBEN

1. EMPLOYEE INFORMATION TO BE COMPLETED BY THE EMPLOYEE ONLY

Social Security Number _____ Last Name _____ First Name _____ MI _____

Mailing Address _____ City _____ State _____ Zip Code _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced Date of Birth _____ / _____ / _____ Sex ☐ Female ☐ Male Hours Worked Per Week _____

☐ Address Change ☐ Name Change (previous name)_____ Telephone # Home (_____) _____ Work (_____) _____

☐ I waive the following coverage(s) ☐ Medical Signature _____

If you are waiving medical coverage you must Sign and indicate your medical carrier. _____
If you are waiving Medical coverage you are automatically entitled to Life / AD&D and Short Term Disability

2. BENEFIT OPTIONS

☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Employee + Family

IS THIS A QUALIFYING EVENT? YES ( ) NO ( ) LIST THE EVENT AND DATE_____

3. LIST SPOUSE AND DEPENDENTS UNDER 26 TO BE COVERED ON THE PLAN

Last Name	First Name	MI	Social Security Number (Mandatory)	Relationship	M/F	DOB	ADD (X)	TERM (X)	OTHER INSURANCE
				Spouse					

4. OTHER INSURANCE INFORMATION MUST BE COMPLETED

Policy Holder_____ Carrier Name_____
Date of Birth of Policy Holder _____/_____/_____ Other Plan Policy Effective Date_____/ Policy Number_____
If anyone is currently on Medicare, please list information. ID Number_____ Part A Effective Date_____ Part B Effective Date_____

5. I hereby appoint my Employer as agent to receive all notices concerning premiums, coverage and termination and authorize my payroll deductions as required for coverage. I understand that any false or inaccurate information may result in the termination of coverage or non payment of benefits. I hereby authorize any provider of service to release to AmeriBen any information regarding diagnosis, treatment or prognosis for any person listed on this application.

SIGNATURE OF EMPLOYEE _____ **DATE** _____

6. TO BE COMPLETED BY HUMAN RESOURCES DEPARTMENT ONLY

☐ New Hire Hire Date_____/_____/_____ Effective Date _____/_____/_____ ☐ Termination of Insurance_____/_____/_____
☐ Change Effective Date of Change_____/_____/_____ ☐ Add/Term Dep(s) Qualifying Event_____
☐ Rehire Rehire Date_____/_____/_____
☐ Retiree Retiree Effective Date _____/_____/_____
☐ Leave Of Absence Start Date _____/_____/_____

Salary $_____ _____ _____/_____/_____
HR Dept. Initials Date