

# Employee Change Form



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## EMPLOYEE INFORMATION

Employer \_\_\_\_\_

Employee Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle Initial \_\_\_\_\_

Social Security Number \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

## NAME OR ADDRESS CHANGE

Name Change (From): \_\_\_\_\_ (To): \_\_\_\_\_

Address Change (From): \_\_\_\_\_ (To): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## CHANGE IN STATUS (IF ALLOWED BY PLAN)

For a complete list of allowable changes, please contact your employer. In order to be considered a qualifying event, changes listed below must affect your eligibility.

Marital Status (please describe): \_\_\_\_\_

Number of Dependents (please describe): \_\_\_\_\_

Employment Status (please describe): \_\_\_\_\_

Spouse/Dependent's Eligibility under an employer's plan (please describe): \_\_\_\_\_

Cost or coverage (please describe): \_\_\_\_\_

*(Please note: Changes in cost or coverage do not allow for changes to the Unreimbursed Medical Expenses Account)*

Change in Beneficiary: From: \_\_\_\_\_ To: \_\_\_\_\_

Other (please describe): \_\_\_\_\_

## AUTHORIZATION

**Changes must be made within 30 days of the qualifying event.** Date of the qualifying event: \_\_\_\_\_

Effective \_\_\_\_\_ (the first day of the next payroll period), I hereby request that the new amount listed below be withheld from my paycheck due to the above qualifying event.

Employer Disbursed Premiums \$ \_\_\_\_\_

Unreimbursed Health Expenses \$ \_\_\_\_\_  
(if allowed by plan)

Dependent Care Expenses \$ \_\_\_\_\_

Other Health-Related Premiums \$ \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Employer Signature: \_\_\_\_\_

Date: \_\_\_\_\_