CompBenefits
P.O. Box 769769
Roswell, GA 30076-8228
FAX: 770-998-6871
Attn: Enrollment

FOR OFFICE USE ONLY		
Group Number	Effective Date	Cov.

CHANGE REQUEST FORM

INSTRUCTIONS

1. Please use pen: print clearly and press hard.
2. Complete all the information requested.
3. Sign and date this form - Section D.
4. Please forward completed form to your personnel office.

USE THIS FORM TO MAKE THE FOLLOWING CHANGES/
CHECK CHANGES DESIRED AND COMPLETE THE APPROPRIATE SECTION

❑ Name change of subscriber - complete Sections A & D
❑ Change of address - complete Sections A & D
❑ Cancel coverage - complete sections A, B & D
❑ Dependent Changes:
❑ Add Dependents ❑ Remove Dependents
Complete Section A, C & D

Section A

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	INITIAL	HOME PHONE	BUSINESS PHONE

ADDRESS	CITY	STATE	ZIP CODE	COUNTY

Section B

❑ CANCEL COVERAGE ❑ Other:________________

CHANGE COVERAGE TO:
❑ Single ❑ Family ❑ COBRA ❑ Other:________________

Section C

		SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	STUDENT AGE 19-23	OTHER DENTAL COVERAGE
01	SPOUSE				YES NO	
02	DEPENDENT				YES NO	
03	DEPENDENT				YES NO	
04	DEPENDENT				YES NO	
05	DEPENDENT				YES NO	

*If The dependent is between ages 19 and 23, specify academic institution where enrolled: ________________
**Explain of dental coverage: ________________
If adding spouse,give date of marriage: __ /__ /__ If child is being adopted, give date of adoption. __ /__ /__. ________________
Give reason for adding or removing dependents if not Open Enrollment: ________________

Section D

EFFECTIVE DATE OF COVERAGE	EMPLOYER NAME AND GROUP NO.	EMPLOYEE SIGNATURE	DATE