LE MOYNE
SPIRIT. INQUIRY. LEADERSHIP. JESUIT.

Office of Human Resources
1419 Salt Springs Road
315.445.4156 (p)
315.445.6023 (f)

Benefit Change Form

Name: _____ SSN: _____

Address: _____

City, State Zip: _____

Date of Birth: _____ Gender: _____ Date of Hire: _____

Email Address: _____ Phone #: _____

Marital Status: ☐ Single; ☐ Married; ☐ Legally Separated; ☐ Divorce/Marital Status Event Date: _____

Medicare # (if applicable): _____ Part A Effective: _____ Part B Effective: _____

☐ I do not have a spouse or any dependents, and therefore, I do not have to complete this section.

Name	SSN	Date of Birth	Gender	Relationship

Other coverage information

Have you, your spouse, or any enrolled dependent had other coverage within the last 63 days? ☐ Health ☐ Dental

If checked "Health" and/or "Dental," are you keeping the additional coverage? Health? ☐Yes ☐No; Dental? ☐Yes ☐No

Who did the other plan cover? ☐ Self ☐ Spouse ☐ Children

Other insurance carrier name? _____

Name of policyholder: _____

Policy ID #: _____ Effective date: _____ Term date: _____

Please check coverage type and person(s) to be covered:

☐ Medical: ☐ New enrollee ☐ Change in plan ☐ Change in dependents ☐ Term coverage: _____
☐ PPO-L ☐ HealthyBlue ☐ SimplyBlue (please complete HSA form)
☐ single ☐ emp & spouse ☐ emp & dependents ☐ family
Please specify dependents to be ☐ removed or ☐ added (if applicable): _____

☐ Dental: ☐ New enrollee ☐ Change in dependents ☐ Term coverage: _____
☐ single ☐ family
Please specify dependents to be ☐ removed or ☐ added (if applicable): _____

☐ Flexible Spending Acct: ☐ Health Care: Pay period amt: _____ x #of pay periods: ___ = Total amt: _____
☐ Automatic Claims Transfer (if you are enrolled in our Medical and/or Dental plan, claims can be submitted automatically by your physician)
☐ Dependent Care: Pay period amt: _____ x #of pay periods: ___ = Total amt: _____
☐ Direct deposit election (complete this section if you want Direct Deposit)
Type of acct: ☐ Checking ☐ Savings
Name of Bank: _____
Routing #: _____ Acct #: _____

Participant Signature: _____ Date: _____

To be completed by the employer:

Benefit Log: _____ Delta Dental: _____

Effective date: _____ BCBS: _____ EBS-RMSCO: _____