MERITAIN® HEALTH
An Aetna Company

Employer: **Steamfitters Local 439** ***Group#:*** **17017** **Change Form**

***required fields**

* Employee Name	*Social Security Number	*Date of Birth	Phone Number

ADDRESS OR PHONE NUMBER CHANGE COMPLETE THIS SECTION:				
OLD ADDRESS	Mailing Address	City	State	Zip
NEW ADDRESS	Mailing Address	City	State	Zip
PHONE NUMBER CHANGE	Old Phone Number	New Phone Number		*Effective Date

NAME CHANGE COMPLETE THIS SECTION:			
NAME CHANGE	Old Name	New Name	*Effective Date

DIVISION CHANGE COMPLETE THIS SECTION:			
DIVISION CHANGE	Old Division	New Division	*Effective Date

DEPARTMENT/LOCATION CHANGE COMPLETE THIS SECTION:			
DEPARTMENT/ LOCATION CHANGE	Old Department/Location	New Department/Location	*Effective Date

TERMINATION COMPLETE THIS SECTION:			
EMPLOYEE TERMINATION	Termination Date	Coverage End Date	
Qualifying Event (Check One)	❑ Voluntary or involuntary termination of employment for reasons other than gross misconduct ❑ Reduction in the number of hours of employment		
Type of Coverage	**Plan Elected**	**Coverage Level**	
❑ Medical/Rx		❑ Single ❑ Employee + Spouse ❑ Employee + Child ❑ Family	
Voluntary Products Termination		❑ STD	
SPOUSE TERMINATION	Termination Date	Spouse Name and Date of Birth:	
	Qualifying Event (Check One) ❑ Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct ❑ Reduction in the hours worked by the covered employee ❑ Covered employee's be coming entitled to Medicare ❑ Divorce or legal separation of the covered employee ❑ Death of the covered employee		
DEPENDENT TERMINATION	Termination Date	Dependent Name and Date of Birth:	
	Qualifying Event (Check One) ❑ Loss of dependent child status under the plan rules		

Special Notes:

Employer Signature/Date:	**Employee Signature/Date:**