ACCE EMPLOYEE INSURANCE CHANGE FORM

EMPLOYEE BENEFIT INSURANCE PLANS

☐ Name Change ☐ Address Change ☐ Salary Change ☐ Beneficiary Change

☐ Employee Termination Date: ________________ Employee terminations are always effective on the last day of the month

1. EMPLOYER INFORMATION

Employer Name ____

2. EMPLOYEE INFORMATION Please write legibly

Last Name ____ First Name _________________________________MI _________

Home Address ____ City, State _________________________________Zip__________

Work Email ____ Employee Title ____

Social Security # ____

Number of hours worked **per week** ____________ Salary (**Annual**) ________________________

3. COVERAGE/BENEFITS AFFECTED Please complete page 2 of this form to change beneficiary election

☐ **Term Life and AD&D**

☐ **Dependent Life**

☐ **Long-Term Disability**

☐ **Short-Term Disability**

☐ **Dental PPO**

☐ **Vision Plan**

☐ **Voluntary Accident w/ Travel Benefits**

Comments____

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4. SIGNATURE This form cannot be processed without Plan Administrator signature

Employer Signature/Title ____ Date __________________

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5. BENEFICIARY INFORMATION

PRIMARY BENEFICIARY

FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATION TO EMPLOYEE	PECENTAGE (*TOTAL MUST = 100%*)

CONTINGENT BENEFICIARY

FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATION TO EMPLOYEE	PECENTAGE (*TOTAL MUST = 100%*)

6. EMPLOYEE SIGNATURE

I authorize the addition or change of my beneficiaries. This form cannot be processed without employee signature

Employee Signature ______________________________ Date ______________

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