

# CPM, Inc. GROUP BENEFITS CHANGE IN STATUS FORM

Group Name: \_\_\_\_\_ Plan #: \_\_\_\_\_  
 Employee Social Security Number: \_\_\_\_\_  
 Employee Name: \_\_\_\_\_  
 Effective Date of Change: \_\_\_\_\_

**Qualifying Event Reason:**

- |  |   |
|--|---|
| <input type="checkbox"/> Marriage (please provide copy of marriage certificate)<br><input type="checkbox"/> Birth<br><input type="checkbox"/> Adoption or Placement of Adoption<br><input type="checkbox"/> Loss of Previous Coverage<br><input type="checkbox"/> Patient Protection and Affordable Care Act<br><input type="checkbox"/> Death | <input type="checkbox"/> Legal Separation or Divorce (COBRA)<br><input type="checkbox"/> Cancel Employee's Coverage(s) – Actively Employed<br><input type="checkbox"/> Cancel dependent's (spouse/child) coverage(s)<br><input type="checkbox"/> Reduction hours of employment (COBRA)<br><input type="checkbox"/> Termination of Employment (COBRA) Date: _____<br><input type="checkbox"/> Other (Please Specify Reason – retiree etc.) _____ |
|--|---|

**Change In Status (Mark All That Apply):**

- Name
- Address
- Change Type of Coverage
- Beneficiary
- Dependent Status (Marriage, Newborn, Divorce, etc.)

**Please Give Change Information:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*Please List Dependents Being Added To Plan:*

Name of Family Member(s) to be Covered	Sex	Date of Birth	Social Security Number	Medical	Dental	Prescription (if applicable)
Spouse						
Child						
Child						
Child						
Child						

I hereby certify that all information on this enrollment form is true and complete; and that I am an eligible employee of the Participating Employer named above, currently working at least 30 hours per week with payroll taxes being withheld by the Participating Employer, and that I am actively at work on this date. I UNDERSTAND THAT MISSTATEMENT OR FAILURE TO DISCLOSE ANY INFORMATION MAY BE USED AS A BASIS FOR RECISSION OF COVERAGE FOR ME AND MY DEPENDENT(S). I understand that the coverage applied for will not become effective unless and until the first premium has been paid and the Company unconditionally approves and accepts the application. I authorize deductions, if any, from any earning toward the cost of coverage.

**AUTHORIZATION:** I hereby authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me or my dependents or my health to give to the Plan Administrator any such information. A photographic copy of this authorization shall be valid as the original.

_____ Signature Date	<b>X</b>	_____ Signature of Employee
_____ Signature Date	<b>X</b>	_____ Signature of Employer