St. Peter's Hospital

Employee Change Form

Reason for Change:

EFFECTIVE DATE

☐ New Enrollment ☐ Status Change ☐ Adding Dependent ☐ Deleting Dependent
☐ Name Change ☐ Address Change ☐ Phone Number Change

_____

1. Employee's Personal Data

_____ _____
Last Name **First** **MI** **Date of Birth** **Social Security Number**

☐ _____ _____
New Last Name **Employee Number**

_____
Mailing Address **City** **State** **Zip Code**

☐ _____
New Mailing Address **City** **State** **Zip Code**

(___) _____ ☐ (___) _____ ☐ Single ☐ Married ☐ Male ☐ Female _____
Home Phone **New Home Phone** **Date of Hire**

2. Medical/Dental

Level of Coverage:
Medical ☐ Premium ☐ Basic **Dental** ☐ Premium ☐ Basic

TO LIST ELIGIBLE DEPENDENTS, THEY MUST BE LESS THAN 26 YEARS OLD.

List all eligible family members to be covered. *Attach a separate sheet if necessary.*

Medical	Dental						
Add Drop	Add Drop	Last Name	First	MI	Date of Birth (M/D/Y)	Sex	SSN
Spouse ☐ ☐	Spouse ☐ ☐					M / F	
Child(ren) ☐ ☐	Child(ren) ☐ ☐					M / F	
☐ ☐	☐ ☐					M / F	
☐ ☐	☐ ☐					M / F	
☐ ☐	☐ ☐					M / F	
☐ ☐	☐ ☐					M / F	

HUMAN RESOURCES USE ONLY: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family
☐ Kronos ☐ Employee File ☐ Dental ☐ Medical ☐ Flex ☐ IS

3. Employee Signature

The above statements are true and correct to the best of my knowledge. I authorize the release of all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. This form supersedes all previous forms I have submitted.

_____
Employee's Signature Date