

# Member Change Form

This form is designed to make any of the changes listed below. Please fill out completely, sign and return to your employer. The signed form **must be submitted within 31 days** of the requested qualifying event or change to ensure timely processing.

**MESSA Member Information (Required)**

**SSN or MESSA ID#:**

CURRENT Name and Address Information				NEW Name and Address Information				Effective Date: _____	
First Name		Last Name		First Name		Last Name			
Address				Address				Apt. #	
City		State	Zip Code		City		State	Zip Code	
Home Phone (      )				Home Phone (      )					
Email				Email					

**Important Reminder:** Do you need to change or update your life insurance beneficiary? You can obtain a **Beneficiary Designation Form** online at [www.messa.org](http://www.messa.org) or by calling MESSA at 888.888.4167.

**Change Code(s) (check all that apply)**

**Qualifying Events:** All changes submitted on this form outside of open enrollment must be due to a qualifying event. **\*Social Security Numbers are required for all dependents.**

- 1 Marriage:** *Date of Marriage:* \_\_\_\_\_ To add a spouse or dependent(s) complete Sections 1 & 3
- 2 Birth:** To add a newborn complete Section 1. Remember to submit Social Security Numbers for newborns when issued.
- 3 Adoption:** To add an adopted child complete Section 1.
- 4 Legal Guardianship:** To add a dependent(s) complete Section 1.
- 5 Sponsored Dependent:** Complete Section 1 to add. There is an additional cost for this coverage and MESSA requires IRS verification.
- 6 Divorce:** *Date of divorce:* \_\_\_\_\_ To delete a spouse and any applicable dependents complete Sections 1 & 3.
- 7 Other Eligible Dependents:** To add an eligible dependent not listed above complete Section 1.

**Other Changes:**

- 8 Delete Dependent:** To delete dependent(s) complete Section 1.
- 9 Cancel Variable Options:** To cancel variable options complete Section 2. *Cancellation of non-PAK Medical requires a Member Application.*
- 10 Dental Coordination of Benefits:** To change dental coverage complete Section 3.
- 11 Legal Name Change:** To change name other than through marriage or divorce requires legal documentation.

**Section 1: Dependents** (All information requested below is required to add or delete a dependent. Only list the dependents affected by the indicated change code.)

First Name	Last Name	Gender M F	Date of Birth (mm/dd/yyyy)	*Social Security Number	Relationship to Member	Change Code (See Above)	Requested Effective Date (mm/dd/yyyy)

**Section 2: CANCEL Variable Options**

**Effective Date:** \_\_\_\_\_

<input type="checkbox"/> Optional Short Term Disability (STD) <input type="checkbox"/> Optional Long Term Disability (LTD) <input type="checkbox"/> Optional Dependent Life	<input type="checkbox"/> Optional Survivor Income Insurance (SII) <input type="checkbox"/> Optional Hospital Confinement (HCI) <input type="checkbox"/> Optional Supplemental Term Life	<input type="checkbox"/> Optional Basic Term Life (BTL) <p style="color: red; font-size: small;"><b>Note:</b> if you are enrolled in Non-PAK Medical, you may <b>not</b> cancel BTL.</p>
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**Section 3: Dental Coordination of Benefits**

**Effective Date:** \_\_\_\_\_

Do you, your spouse or dependents have dental coverage through another source?  Yes  No Who is covered through the source?  Self  Spouse  Dependents

Employee Signature	Date
Authorized Employer Signature and Stamp	Date