Ameritas/VSP Vision Plan – **Status Change Form**

Ameritas
fulfilling life

Subscriber/Employee Name (Last, First, Middle Initial)	Social Security Number	Employee Number

BENEFIT CHANGE OR TERMINATION – EMPLOYEE INITIATED

Please indicate the qualifying event:

○ Marriage	Date:_____	○ Open Enrollment	Date: _____	○ End of Other overage	Date:_____
○ Birth	Date:_____	○ Dep. Open Enroll	Date: _____	○ Divorce	Date:_____
○ Medicare	Date: _____	○ Medicaid	Date: _____	○ Death	Date: _____

ADD OR DROP SELF OR DEPENDENTS

○ ADD ○ DROP _____ RELATIONSHIP:_____ SS# ____/___/_____ DOB:_____

○ ADD ○ DROP _____ RELATIONSHIP:_____ SS# ____/___/_____ DOB:_____

○ ADD ○ DROP _____ RELATIONSHIP:_____ SS# ____/___/_____ DOB:_____

○ ADD ○ DROP _____ RELATIONSHIP:_____ SS# ____/___/_____ DOB:_____

NAME CHANGE

Please indicate new name: First_____ Middle_____ Last_____

ADDRESS CHANGE - Please write new address below:

Address:	City:	State:	Zip:

DEPENDENT ADOPTION OR FOSTER CARE **Attach supporting documentation. The subscriber/employee will be notified once a determination has been made as to whether the child does or does not qualify for coverage under the plan.**

(Child's Name)_____ is an adopted child(ren) or has been placed with participant for adoption or foster care. Date of placement for adoption, date adoption was final, or date of foster care placement, whichever occurred first: _____

CHILD SUPPORT ORDER **Attach supporting documentation. The subscriber/employee will be notified once a determination has been made as to whether the child does or does not qualify for coverage under the plan.**

A child support order has been issued for: _____.
(Name of Child or Children)

_____ _____
Plan Representative – Hog Slat Date

_____ _____
Subscriber/Employee Date