

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		Apt. #		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 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 Survivor Income Insurance (SII) | <input type="checkbox"/> Optional Basic Term Life (BTL) |
| <input type="checkbox"/> Optional Long Term Disability (LTD) | <input type="checkbox"/> Optional Hospital Confinement (HCI) | Note: if you are enrolled in Non-PAK Medical, you may not cancel BTL. |
| <input type="checkbox"/> Optional Dependent Life | <input type="checkbox"/> Optional Supplemental Term Life | |

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