

# EMPLOYEE CHANGE/TERMINATION FORM

Mail Completed Form to: SBS, Inc., P. O. Box 7777, Lancaster, Pennsylvania 17604-7777 Tel: 717-581-1300



**Box 1 through 5 MUST be completed for all changes and/or terminations.**

1) Employee's Last Name, First Name, Middle Initial		2) Social Security Number (Member ID)		
3) Home Address <input type="checkbox"/> Check if New Address E-Mail _____				
Street	City	State	Zip	Home Phone Number
4) Company/Employer Name		5) Group #		

<b>Name Change</b>	From:	To:
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<b>B. Beneficiary Change</b>	In accordance with the group plan, the employee revokes the previous Beneficiary designation and chooses the following to receive benefits in the event of death.
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Primary Beneficiary	Name:	Relationship:
Contingent Beneficiary (if no Primary Beneficiary is living)	Name:	Relationship:

<b>C. Coverage Waiver</b>	<b>IMPORTANT:</b> The employee understands that if coverage is waived and is applied for at a later date, he and his dependents may be treated as a late enrollment under the terms of the plan/policy. <b>EMPLOYER:</b> Any mid-year status changes that are made outside of the plan's open enrollment period must conform to applicable Section 125 and plan document requirements.
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The employee has been given an opportunity to apply for group coverage and has decided not to elect coverage for:

Employee     Dependents     Employee and Dependents     Spouse Only     \_\_\_\_\_

Type of Coverage Decline \_\_\_\_\_ Reason \_\_\_\_\_

Is spouse insured through another employer: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Insurance Company _____
If Yes Employer Name _____	Policy # _____

**Employee Signature:** \_\_\_\_\_

**Sections D and E are to be completed by the Employer only.**

<b>D. Employee Status Change</b>	Effective Date of Change (Mo/Day/Yr) ____/____/____
<input type="checkbox"/> Class or Position Change	The employee is now in the following new class or position _____
<input type="checkbox"/> Salary Change	The employee's salary changed to: _____ per <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year
<input type="checkbox"/> Reinstatement	Reinstate coverage for employee's Reason _____ (if applicable, rehire date ____/____/____)
<input type="checkbox"/> FMLA Leave	Begin Date _____ Expected Return Date _____ (12 week maximum)

<b>E. Termination Notice</b>	Effective Date of Termination (Mo/Day/Yr) ____/____/____
Reason for Termination _____	Terminate FSA Benefit (Mo/Day/Yr) ____/____/____

**Important:** All claims prior to the termination date must be submitted within 90 days after employment ends. Please be aware that your coverage has terminated in accordance with the terms of the group plan on the above date.

Employer Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_  
(applies to all changes above)