

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 6 MUST be completed for all changes and/or terminations.

1) Employee's Last Name, First Name, Middle Initial	2) Social Security Number
3) Home Address <input type="checkbox"/> Check if New Address	
Street _____ City _____	State _____ Zip _____ Home Phone Number _____
4) Company/Employer Name	5) Group # _____
6) Employee Signature (If Employee is not available to sign, write: "Not available for signature" and sign your own signature.	
Date: _____	

Name Change	From: _____	To: _____
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B. Smoker Status Change	The Employee is now a <input type="checkbox"/> Non-Smoker <input type="checkbox"/> Smoker To be a non-smoker the employee must have stopped smoking for a 12 month period.
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C. Beneficiary Change	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: _____
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Contingent Beneficiary (if no Primary Beneficiary is living)	Name: _____	Relationship: _____
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D. Coverage Waiver	IMPORTANT: The employee understands that if coverage is waived and insurance 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.
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The employee has been given an opportunity to apply for group insurance 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 # _____

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

E. Employee Status Change	Effective Date of Change (Mo/Day/Yr) ____/____/____
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<input type="checkbox"/> Class or Position Change	The employee is now in the following new class or position _____
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<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
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<input type="checkbox"/> Reinstatement	Reinstate coverage for employee – Reason _____ (if applicable, rehire date ____/____/____)
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<input type="checkbox"/> FMLA Leave	Begin Date _____ Expected Return Date _____ (12 week maximum)
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F. Termination Notice and Notice of Conversion Privilege	Effective Date of Termination (Mo/Day/Yr) ____/____/____
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Reason for Termination _____	Terminate FSA Benefit (Mo/Day/Yr) ____/____/____
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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. If applicable, under a conversion privilege contained in the group plan, it may be possible for you to obtain an individual insurance policy. This would not require a medical exam if coverage is applied for and the required premium is paid within 31 days of the termination date. If interested in obtaining this coverage, write to us immediately, giving a current address and enclosing a copy of this notice.

Policyholder Authorized Signature _____	Date _____
(applies to all changes above)	