



REQUEST FOR CHANGE OF STATUS

Employee Name - Last	First	Middle Intl.
Employee Social Security Number		
Name of Company Where Employed		

ADD Dep Cov	Employer #	Eff. Date
Incr/Decr	EE #	Coverage

EMPLOYEE CHANGE OF NAME

Term Dep Cov	Adjustment	App=A Decl=D
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New Name Last	First	Middle Intl.
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TERMINATION OF DEPENDENT(S)

If adding spouse, enter date of marriage:

Mo _____ Day _____ Year _____

Requested Date of Termination

Mo _____ Day _____ Year _____

Dependent Name	Full Time Student?	Relationship	Sex	Date of Birth

All Dependents _____ **REASON:**

Death _____

Spouse _____ Marriage _____

Divorce _____

If Child, Please give name _____ Over Ins. Age _____

Age 65 _____

Other _____

If other, please explain:

Signature (In Ink)

Date Signed

Please Return Completed Form To:
 Matrix Insurance Marketing, Inc.
 1225 So. Weller St., Suite 320
 Seattle, WA 98144
 Phone: 206.521.9451 Fax: 206.521.9554