CAJUN INDUSTRIES, LLC - CHANGE REQUEST FORM (V.10.2014)

Employee Name: _____ Social Security #: _____

A. Add or Delete Dependent(s)

Action to Take: ☐ Add ☐ Delete

Reason: ☐ Open Enrollment ☐ Qualifying Event (list) _____ Date of Event _____

Relationship	First & Last Name	Plan to Change	Date of Birth	SSN	Sex (circle one)
		[ ] Health [ ] Vision [ ] Dental			Male or Female
		[ ] Health [ ] Vision [ ] Dental			Male or Female
		[ ] Health [ ] Vision [ ] Dental			Male or Female
		[ ] Health [ ] Vision [ ] Dental			Male or Female
		[ ] Health [ ] Vision [ ] Dental			Male or Female

B. Change Plan Type

Change: ☐ **FROM** Plan I (Traditional Plan) **TO** Plan II (High Deductible Plan)
☐ **FROM** Plan II (High Deductible Plan) **TO** Plan I (Traditional Plan)

C. Address/Name Change(s)

Change(s) is/are for: ☐ Employee ☐ Dependent ☐ All
Effective Date: _____ Reason for Change: _____
New Name: _____ New Phone #: _____
New Address: _____
New City/State/Zip: _____

D. **Change of Beneficiary**

Subject to the terms of the Group Policy(ies), I hereby revoke any and all designations and option elections previously made by me and direct the payment under the policy to the beneficiary listed below. Unless otherwise provided, if more than one is designated in any one class, each beneficiary in the same class shall share equally.

Name of Beneficiary: _____ Relationship to Insured: _____
Address of Beneficiary: _____
City/State/Zip: _____

E. Cancellation of Coverage ☐ Health ☐ Dental ☐ Vision ☐ Short-Term Disability

Reason: ☐ Open Enrollment ☐ Qualifying Event (list) _____ Date of Event _____

I HEREBY AGREE THAT MY BENEFITS WILL BE CHANGED AS SHOWN ABOVE

Employee: _____ _____
Signature in Ink **Date**

FOR OFFICIAL USE ONLY

Group Number(s): (H)_____ **(D)**_____ **(V)**_____

Member Number(s): (H)_____ **(D)**_____ **(V)**_____

Cajun Authorizing Representative:_____ **Effective Date:** _____