EMPLOYEE MAINTENANCE FORM
GROUP PLANS

RESET FORM

A. EMPLOYER INFORMATION

Employer name: _____ Employee number: Select One

City: _____ State: IL ZIP code: 60187-0969

B. EMPLOYEE INFORMATION

☐ Check if address change ☐ Check if name change

Employee name: _____

Employee address: _____

City: _____ State: _____ ZIP code: _____

Social Security number (last four digits): _____ Telephone: _____

Marital status: ☐ Married ☐ Single

Country of destination: _____ Airport code: _____ Effective date: _____

C. TYPES OF CHANGES (INDICATE ALL APPROPRIATE CHANGES BY SELECTING THE APPROPRIATE BOXES.)

☐ Discontinue Coverage

Dental plans

☐ For myself

☐ For my spouse

☐ For eligible children

Coverage (check one):

☐ Premier Dental Care Plan

☐ Cigna Dental Care® DHMO Plan

HMO office ID number: _____

☐ Cigna Global Dental Basic

☐ Cigna Global Dental Plus

Supplemental Accidental Death and Dismemberment

☐ For myself Amount: $ Select One

☐ For Affiliated Spouse Amount: $ Select One

☐ For my spouse Amount: $_____ (50% of employee volume)

Optional term life (an increase in coverage requires an Evidence of Good Health Form)

☐ For myself Amount: $ Select One

☐ For Affiliated Spouse Amount: $ Select One

☐ For my spouse Amount: $_____ (cannot exceed 50% of employee volume)

Child Life (an Evidence of Good Health Form is required)

☐ Child Life Amount: $ Select One

For dependent(s) to be covered, provide the following information:

Last name	First name	MI	Social Security Number	Date of birth	Relationship	Sex M/F
			_____	_____	Self	—

Employee signature: _____ Date: _____

Employer signature: _____ Date: _____

Email to *Benefits@Team.org*

GuideStone®