EMPLOYEE MAINTENANCE FORM
GROUP PLANS

RESET FORM

A. EMPLOYER INFORMATION

Employer name: _____ Employer number: _____

City: _____ State: _____ ZIP code: _____

B. EMPLOYEE INFORMATION

☐ Check if address change ☐ Check if name change

Employee name: _____

Mailing 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 PLACING AN "X" IN THE APPROPRIATE BOXES.)

☐ Add Coverage ☐ Change coverage

Dental plans

☐ For myself

☐ For my spouse

☐ For eligible children

Coverage (check one):

☐ Premier Dental Care Plan

☐ Choice Dental Care Plan

☐ Cigna Dental Care® DHMO Plan

DHMO office ID number: _____

Supplemental Accidental Death and Dismemberment

☐ For myself Amount: $_____

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

Decrease optional term life

☐ For myself Amount: $_____

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

Salary change

☐ Salary increase

☐ Salary decrease

☐ New monthly salary (_____)

Other changes

☐ Marital status: _____

☐ Class change: _____

☐ Other: _____

Leave of absence ☐ Paid ☐ Unpaid

Reason: ☐ FMLA ☐ General ☐ Military

Coverage: ☐ Medical ☐ Life ☐ Dental

☐ Accident ☐ Vision

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

Employee signature: _____ Date: _____

Employer signature: _____ Date: _____

Return to: GuideStone, Insurance Services — Group Plans, 5005 LBJ Freeway, Ste. 2200, Dallas, TX 75244-6152
Or fax to: (877) 834-1025

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