

## UCAR BENEFIT CHANGE FORM

**A** Emp ID #: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Please check here if this is a new address:  Social Security Number: \_\_\_\_\_

**B** HEALTH CARE COVERAGE:  
 I would like to change my current membership to: Ind  Ind+1  Family   
 Reason for Change: \_\_\_\_\_ Date of event: \_\_\_\_\_  
 Complete the following information: I need to: Add  Change  Delete   
 Self: Last Name: \_\_\_\_\_ First: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Sex: Male  Female   
 Social Security Number: \_\_\_\_\_  
 If you select Option I, choose a primary care provider: \_\_\_\_\_  
 Is this doctor your current physician? Yes  No   
 Spouse: Last Name: \_\_\_\_\_ First: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Sex: Male  Female   
 Social Security Number: \_\_\_\_\_  
 If you select Option I, choose a primary care provider: \_\_\_\_\_  
 Is this doctor your current physician? Yes  No   
 Dependent: Last Name: \_\_\_\_\_ First: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Sex: Male  Female   
 Social Security Number: \_\_\_\_\_  
 If you select Option I, choose a primary care provider: \_\_\_\_\_  
 Is this doctor your current physician? Yes  No

**C** BENEFICIARY CHANGES: I wish to change my beneficiary(ies) on the following:

	Insurance	Beneficiary	Relationship	Primary or Secondary
All Benefit Eligible Employees have Life, AD&D & Travel	Life	_____	_____	_____
	AD&D	_____	_____	_____
	Trvl/AD&D	_____	_____	_____
		_____	_____	_____
	Opt AD&D	_____	_____	_____

**D** CHANGE IN SPENDING ACCOUNT CONTRIBUTIONS: Change my per-pay-period contribution(s) as follows:  
 Health Care Spending Account: from \$ \_\_\_\_\_ to \$ \_\_\_\_\_ (per pay period)  
 Dependent Care Spending Account: from \$ \_\_\_\_\_ to \$ \_\_\_\_\_ (per pay period)  
 Health Savings Account: from \$ \_\_\_\_\_ to \$ \_\_\_\_\_ (per pay period)  
 Reason for Change: \_\_\_\_\_ Date of event: \_\_\_\_\_  
 \* (HR use only) Revised target amounts: Health: \_\_\_\_\_ Dpnd: \_\_\_\_\_ HSA: \_\_\_\_\_

**E** I authorize UCAR to make the changes as indicated above. If contributions are required for any of the above coverages, I authorize UCAR to deduct such contributions from my earnings until further notice.  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_