

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 [ ] No Coverage [ ]
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: \_\_\_\_\_
Spouse: Last Name: \_\_\_\_\_ First: \_\_\_\_\_
Birth Date: \_\_\_\_\_ Sex: Male [ ] Female [ ]
Social Security Number: \_\_\_\_\_
Dependent: Last Name: \_\_\_\_\_ First: \_\_\_\_\_
Birth Date: \_\_\_\_\_ Sex: Male [ ] Female [ ]
Social Security Number: \_\_\_\_\_
Dependent: Last Name: \_\_\_\_\_ First: \_\_\_\_\_
Birth Date: \_\_\_\_\_ Sex: Male [ ] Female [ ]
Social Security Number: \_\_\_\_\_
Dependent: Last Name: \_\_\_\_\_ First: \_\_\_\_\_
Birth Date: \_\_\_\_\_ Sex: Male [ ] Female [ ]
Social Security Number: \_\_\_\_\_

C

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: \_\_\_\_\_

D

I authorize UCAR to make the changes as indicated above. If contributions are required for any of the above coverage, I authorize UCAR to deduct such contributions from my earnings until further notice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_