ADD: FROM: TO:

EMPLOYEE BENEFIT STATUS CHANGE FORM
PALM BEACH COUNTY FIREFIGHTERS EMPLOYEE BENEFITS FUND

This form is to be used for changes to benefit elections. Please complete ALL of the employee information and check the appropriate boxes to your choices. This form must be signed by the Employee.

EMPLOYEE INFORMATION: (PLEASE PRINT – ALL BLANKS MUST BE COMPLETED)

Last Name		First Name	MI
Sex ☐ Male ☐ Female	Date of Birth	Social Security Number	

☐ **ADD DEPENDENT**

First Name	Last Name	MI	Dependent's SS#	Relationship	Date of Birth (mm/dd/yy)
				SPOUSE ☐ SON ☐ DTR ☐ OTHER ☐ ______	
				SPOUSE ☐ SON ☐ DTR ☐ OTHER ☐ ______	
				SPOUSE ☐ SON ☐ DTR ☐ OTHER ☐ ______	
				SPOUSE ☐ SON ☐ DTR ☐ OTHER ☐ ______	
				SPOUSE ☐ SON ☐ DTR ☐ OTHER ☐ ______	

☐ **TERMINATE DEPENDENT**

First Name	Last Name	MI	Dependent's SS#	Relationship	Date of Birth (mm/dd/yy)
				SPOUSE ☐ SON ☐ DTR ☐ OTHER ☐ ______	
				SPOUSE ☐ SON ☐ DTR ☐ OTHER ☐ ______	
				SPOUSE ☐ SON ☐ DTR ☐ OTHER ☐ ______	
				SPOUSE ☐ SON ☐ DTR ☐ OTHER ☐ ______	
				SPOUSE ☐ SON ☐ DTR ☐ OTHER ☐ ______	

☐ **TERMINATE COVERAGE** ALL COVERAGE ☐ MEDICAL ☐ DENTAL ☐

☐ **NAME CHANGE** New Name ____________________ ____
First *Last*

☐ **ADDRESS CHANGE** New address ____
Street *City* *State* *Zip*

☐ **TELEPHONE #** New Number____

☐ **COBRA COVERAGE** COBRA Effective Date________________ COBRA Termination Date_____________________

EMPLOYER NAME – PBCFF EMP. BENFITS FUND	EFFECTIVE DATE OF ACTION (MM/DD/YYYY)
GROUP NUMBER - 4030	COMMENTS
____ / __________ *Signature of Authorized Representative* *Date*	____ / ______________ *Employee Signature* *Date*