

3 Ways To Submit Your Claim Form and Receipts

E-mail: Claims@Div125.com

Fax 954-983-9695 or 954-983-0574

6600 Taft Street Suite 304, Hollywood, FL 33024

Employee Change In Status Form

Participant Information

nployer Name:				
st Name:		Last Name:	SSN:	· -
	F	Reason for Char	nge in Status	
Accounts and your B	Benefit Plan	Elections. Changes must be submitted within t	the changes listed below qualifies you to change your Re hirty (30) days after the event and will become effective you make must relate directly to the change in status wh	on the first
Open Enrollm Employee	ent on Ma	arketPlace Exchange (medical insur Dependent	ance coverage only).	
Change In Lega Marriage	ıl Marital S	·		
Change In Num Birth Or Ado		pendents: Child Death Of A Spouse Or Depende	ent Court Order	
Termination Or Employee		cement Of Employment By: Dependent		
Employee	Spouse	Or Unpaid Leave Of Absence (Must A Dependent	-	
Explain:			Requirements: endent (Must Result In Change In Eligibility):	
Significant Cha	nge In The	Health Coverage Of The Employee Or	Spouse Attributable To The Spouse's Employm	ent:
Entitlement To Explain:		Or Medicaid:		
Change In Dayo Explain:	care Provi	der Or In The Cost Of Dependent Dayca	re:	
		Employee S	ignature	
Please sen	d this co	ompleted form, along with a r	new election form, to <u>claims@div125</u>	i.com
Effective Date	of New	Coverage://	Effective Payroll Date:/	/
Employee Sig	nature: _			