Benefit Advantage
Mail: PO BOX 5545 DePere, WI 54115-5545
Phone: (800) 686-6829
Fax: (920) 339-0038

STATUS CHANGE REQUEST FORM

Name: _____ **Social Security Number**: _____

Former Employer: _____

Convert to Lower / Single Level of Coverage - Drop Dependent effective _____/_____/_____

Name(s) of Dependent(s) being dropped: _____

- Other Coverage
- Medicare
- Divorce *(required to provide copy of Divorce Decree within 60 days of receipt)*
- Loss of Dependent Status *(required to notify Benefit Advantage within 60 days of qualifying event)*
- Other (please explain): _____

Any dependent 18 years and older being dropped from the insurance coverage is required to sign the Request Form.

Spouse Signature: _____ Date: _____

Dependent(s) Signature(s): _____ Date: _____

_____ Date: _____

Add Dependent *(required to notify Benefit Advantage within 30 days from the Qualifying Event)*

- Name of Dependent being added: _____
- Newborn Child date of birth _____/_____/_____ or Marriage effective date: _____/_____/_____

Address Change

Previous Address: _____ New Address: _____

_____ _____

_____ _____

Participant Signature: _____ **Date:** _____

In the event you email your completed request to Benefit Advantage and do not receive a confirmation, please resubmit and verify that Benefit Advantage has received your communication.

Complete Status Change Request Form and return to Benefit Advantage: PO Box 5545, DePere WI 54115 or email to COBRA@benadvan.com or fax to 920-339-0038.