EVANGELICAL
COMMUNITY HOSPITAL
Employee Benefit/Address Change Form

Instructions: This form is used for the following:

1. Current employees making changes to existing employee demographic information
2. Current employees making changes to existing benefit options.
3. Address changes will update employee record and benefits. To update patient address please contact Patient Access at 522-2566.

Effective Date of Change: Company: Select...

Reason for Change:

Type of Change: (Please check all that apply)

- ☐ Address Change
- ☐ Benefit Change due to Qualifying Event (*Proof Required*)
- ☐ Marital Status *(Proof Required)*
- ☐ Name Change *(Proof Required)*
- ☐ Phone Change

Gender: ○ Male ○ Female User ID: 3-4 digit computer login (e.g. aaa1)

DOB: Badge #:

Hire/Rehire Date: SS#:

First Name: MI: Last:

Prior Name(s):

Address 1:

Address 2:

City: State: Zip:

Primary Phone: Alternate Phone:

County: Boro/Township:

School District: Email:

Spouse Name:

Check Benefits to which Changes Apply

Changes to benefits can only occur if you have a qualifying event (i.e. birth of a child, marriage, divorce, student status change) and changes must be made within 30 days of qualifying event

- ☐ Health Insurance (Geisinger Health Options Group 117441)
- ☐ Prescriptions (OptumRx)
- ☐ Delta Dental/PPO with POS - Group #4494
- ☐ Flex Spending (Discovery Benefits)
- ☐ Vision Insurance (Vision Benefits of America)

☐ Voluntary Life Insurance (Cigna)
☐ 401K (Prudential - 300044)

Benefit Coverage Changes

(select all that apply)

Marital Status: From: Select... To: Select...

Martial Status Effective Date:

Coverage Type: From: Select... To: Select...

Plan Type: Select... Select...

Plan Status: Select... Select...

If enrolling in the HDHP with an HSA, indicate the **bi-weekly** amount you would like to contribute toward your HSA:

If adding your spouse to the health coverage, are they offered other employer sponsored coverage? ○ Yes ○ No

Dependents (Spouse & Dependent Children):

Last Name:	First Name:	SS#:	Relationship:

DOB: Sex: ○ Male ○ Female Add/Delete ○ Add ○ Delete

Additional Questions or Comments for HR:

Signature of Employee: Date:

Signature of Employer: Date:

If you want to print a copy for your records, you must select Print View then either go to File Print or click on the printer icon, BEFORE you submit the form.

HR Use Only

Effective Pay Period Ending:

Notes:

Form Status: Select...