FRINGE BENEFIT RESOURCES

A Company of Montana Health Network

REQUEST FOR CHANGE FORM

Company Name: _____ Date: _____

Policyholder Name: _____

Effective Date of Change: _____

Type of Change: _____

(Name, Address, Position, Termination/Retirement, Qualifying Life Event, Other)

Name Change

Change Name of:
(Policyholder, Spouse, Dependent) _____

Change Name to: _____

Reason: _____
(Marriage, Divorce, Correction, Etc)

Address Change

Change Address to: _____

Position Change

Change Position to:
(Full-Time, Part-Time, Non-Benefit Eligible, Terminated, Retired) _____

Other Change _____

Signature _____ **Date**_____

Additional Notes