

**METLIFE SMALL MARKET
CHANGE REQUEST**

GROUP NAME: _____

GROUP NUMBER: _____

TYPE OF ELIGIBILITY CHANGE: (Please list be

- | | | |
|-------------------------|--|---|
| 1. Name Change | 6. Partial Cancellation (List Coverages to be Cancelled) | 10. COBRA Enrollment (Attach Election Form) |
| 2. Address Change _____ | | 11. COBRA Termination |
| 3. Cancel Spouse | 7. Cancel All Coverage - Termination of Employment | 12. Change Employee from DHMO to PPO* |
| 4. Cancel 1 Child | 8. Cancel All Contributory Coverage - Request of Active Employee | 13. Change Employee from PPO to DHMO* |
| 5. Cancel All Children | 9. Change Insurance Amount due to Salary Change | 14. Other _____ |

QUALIFYING EVENTS: DATE:

- | | |
|---|-------|
| Q1. Add Dependent – Marriage | _____ |
| Q2. Add Dependent(s) – Birth or Adoption | _____ |
| Q3. Add Dependent(s) – Loss of Coverage** | _____ |
| Q4. Death | _____ |
| Q5. Rehired Employee | _____ |
| Q6. Divorce | _____ |
- ** Proof of loss must be submitted with request for coverage.

All necessary information must be included to avoid processing delays.

COMPLETE FOR ELIGIBLE EMPLOYEE(S)

#	ELIGIBILITY OR QUALIFYING EVENT CHANGE	LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER	BIRTHDAY MO/DAY/YR	SEX	LIST NEW CHANGE (SALARY/ADDRESS, ETC.)	COVERAGES AFFECTED
	EFFECTIVE DATE							

COMPLETE FOR ELIGIBLE DEPENDENT(S)

Employee's Name _____ Employee's Social Security # _____

#	ELIGIBILITY OR QUALIFYING EVENT CHANGE	LAST NAME	FIRST NAME	BIRTHDAY MO/DAY/YR	SEX	LIST NEW CHANGE (SALARY/ADDRESS, ETC.)	COVERAGES AFFECTED
	EFFECTIVE DATE						

COMMENTS: _____

EMPLOYER'S (OR REPRESENTATIVE'S) SIGNATURE _____ () - _____ DATE _____

*Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166. Dental HMO plans in CA, FL and TX are available through a domestic company in the applicable state named SafeGuard Health Plans, Inc. The SafeGuard companies are part of the MetLife family of companies.