Union Employees

NOTICE OF CHANGE IN FAMILY STATUS

SECTION 1: Personal Information

First & Last Name: _____ Social Security No.: _____

Address: _____ Birth date: _____

_____ Employer: _____

_____

Home Phone: ( ) _____ Work Phone: ( ) _____

SECTION 2: Description and Date of Family Status Change

Effective Date of Change: _____ Reason for Change: _____

SECTION 3: Dependents' Information

Add/Delete	Name (Last, First, MI)	Birth date	Relationship	Sex M/F	Other Insurance? If so, Name of Carrier and Effective Date	**You Must Complete This Section If Choosing a MMCP / POS Plan** Provider ID #
☐ ☐	_____	__/__/__	_____	____	_____	_____
☐ ☐	_____	__/__/__	_____	____	_____	_____
☐ ☐	_____	__/__/__	_____	____	_____	_____

Please attach COPIES of the appropriate documentation

Birth Certificate, Marriage Certificate, Death Certificate, Divorce Decree; Adoption / Custody Paperwork; School Schedule for child 19-25 years of age; Medical documentation deeming child incapacitated prior to the age of 19; or Medicare Card.

PLEASE RETURN NOTICE OF CHANGE OF FAMILY STATUS AND APPROPRIATE DOCUMENTATION TO YOUR INSURANCE CARRIER EITHER BY MAIL OR FAX. THE NAME OF YOUR CARRIER CAN BE LOCATED ON YOUR MEDICAL CARD. ***PLEASE WRITE YOUR NAME AND SOCIAL SECURITY NUMBER ON ALL DOCUMENTATION.*** PLEASE NOTE CSX DOES NOT POPULATE THEIR FILES WITH DEPENDENT INFORMATION. THEREFORE, YOU ARE NOT REQUIRED TO FORWARD THIS INFORMATON TO CSX.

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