

CHANGE OF STATUS FORM

(PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING THIS FORM)
(PRINT OR TYPE IN BLACK INK AND IN CAPITAL LETTERS)

125 Barclay Street, New York, NY 10007
Telephone: (212) 815-1234
Fax: (212) 298-9880 or Email: ceu@dc37.net

SECTION A:

SOC. SEC. NO./PID	LAST NAME AS CURRENTLY ENROLLED	FIRST NAME	MID. INT.
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SECTION B: CHANGE OF MEMBER'S INFORMATION (PLEASE FILL IN CHANGES ONLY BELOW THIS LINE)

CHANGE OF LAST NAME										CHANGE OF FIRST NAME										MI
DATE OF BIRTH MONTH / DAY / YEAR										GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE					HOME PHONE () -					
HOME STREET ADDRESS										APT. NO.					CELL PHONE () -					
CITY					STATE					ZIP CODE					WORK PHONE () -					
<p>CURRENT STATUS: Please check one box.</p> <p>NOTE: A date is required if an option other than single is selected</p> <p> <input type="checkbox"/> MARRIED (M) <input type="checkbox"/> SEPARATED (S) <input type="checkbox"/> DIVORCED (D) <small>MONTH DAY YEAR MONTH DAY YEAR MONTH DAY YEAR</small> ___/___/___ ___/___/___ ___/___/___ </p> <p> <input type="checkbox"/> WIDOWED (W) <input type="checkbox"/> DOMESTIC PARTNER (PS) <input type="checkbox"/> SINGLE (S) <small>MONTH DAY YEAR MONTH DAY YEAR</small> ___/___/___ ___/___/___ </p>															Home E-Mail Address (Optional)					

If you enroll any dependents, spouse or domestic partner, it is mandatory that you attach all required documents (i.e. **BIRTH CERTIFICATE, MARRIAGE CERTIFICATE, ADOPTION DOCUMENTS, REGISTRATION OF DOMESTIC PARTNERS or DIVORCE PAPERS**) before any benefits will be provided to dependents, spouse or domestic partner.

SECTION C: SPOUSE OR DOMESTIC PARTNER INFORMATION (If not applicable, please indicate none)

SS# OF SPOUSE/DOMESTIC PARTNER					LAST NAME (if Different)										FIRST NAME										MI
DATE OF BIRTH MONTH / DAY / YEAR					GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE					NAME OF EMPLOYER										DATE OF HIRE MONTH / DAY / YEAR					
WORK ADDRESS										ZIP CODE					WORK PHONE () -										
NAME OF SPOUSE/DOMESTIC PARTNER'S UNION/LOCAL # IF APPLICABLE										PHONE No. of SPOUSE/DOMESTIC PARTNER'S UNION/LOCAL () -															
ADDRESS/ZIP CODE OF SPOUSE/DOMESTIC PARTNER'S UNION/LOCAL # IF APPLICABLE																									

Benefit	Name of Insurer	Address/Zip Code of Insurer	Phone # of Insurer	Policy #	Coverage Individual or Family
Drug					
Dental					
Health Insurance					

SECTION D: DEPENDENT INFORMATION (NOTE - If there are additional dependents, please list on a separate page.)

DEPENDENT SS#	FIRST NAME	LAST NAME (IF DIFFERENT)	DATE OF BIRTH	GENDER
			MONTH DAY YEAR / /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RELATIONSHIP <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEP-SON <input type="checkbox"/> STEP-DAUGHTER OTHER: _____				
DEPENDENT SS#	FIRST NAME	LAST NAME (IF DIFFERENT)	DATE OF BIRTH	GENDER
			MONTH DAY YEAR / /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RELATIONSHIP <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEP-SON <input type="checkbox"/> STEP-DAUGHTER OTHER: _____				
DEPENDENT SS#	FIRST NAME	LAST NAME (IF DIFFERENT)	DATE OF BIRTH	GENDER
			MONTH DAY YEAR / /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RELATIONSHIP <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEP-SON <input type="checkbox"/> STEP-DAUGHTER OTHER: _____				
DEPENDENT SS#	FIRST NAME	LAST NAME (IF DIFFERENT)	DATE OF BIRTH	GENDER
			MONTH DAY YEAR / /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RELATIONSHIP <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEP-SON <input type="checkbox"/> STEP-DAUGHTER OTHER: _____				

ATTENTION : I attest that the information entered on this form is true and accurate and I understand that I and my family may lose benefit coverage if any of the information given on this form is false.

X _____

MEMBER/EMPLOYEE SIGNATURE

_____ DATE

Dear Member:

The function of this form is to provide you with an opportunity to update your DC 37 Health & Security Plan records. Updating your records will ensure that you and your dependents will receive your benefits more efficiently.

PLEASE NOTE THE FOLLOWING:

1. Section "A" must be completed.
2. You must fill in your Social Security Number or PID correctly.
3. Complete only the parts of this form for which the status of you or your dependents has changed.
4. Attach the necessary documentation to your Change of Status Form. (Birth Certificate for additional children, Marriage Certificate for change of name or marital status and Registration Certificate for addition of domestic partner
5. **If you are adding a Spouse/Domestic Partner to your enrollment records, you must also complete the section entitled "Spouse's/Domestic Partner's Employment information."**
6. If you wish to change and/or add a beneficiary, request a Change of Beneficiary form from the Plan office.
7. Finally, this form is not valid unless you, the Member, sign and date above.

Please fax the form to us at (212) 298-9880 or email at eeu@dc37.net for faster processing.

For more information about your Plan and your benefits call the Inquiry Unit at (212)815-1234