Cypress Dental
Employee Change Request Form

GROUP NAME:_____ GROUP NUMBER:_____

TYPE OF ELIGIBLITY CHANGE: (Please check appropriate box)
Cypress must be notified of all changes within 60 days.

☐ Name Change
☐ Address Change
☐ Cancel Spouse (Name):_____
☐ Cancel Child (Name):_____
☐ Cancel All Children (Names):_____
☐ Partial Cancellation (List coverages to be cancelled):_____
☐ Cancel All Coverage - Termination of Employment
☐ COBRA Enrollment (Attach Election Form)
☐ COBRA Termination
☐ Other:_____

Employee Name:	Employee ID#:
Employee Address:	City, State, Zip:
Phone#:	Email Address:

EFFECTIVE DATE OF CHANGE:_____
(Cancellations will be effective the 1st of the month following the effective date of change.)

COBRA:
☐ Employer or COBRA Administrator is responsible for COBRA administration.
☐ Cypress to administer and direct bill COBRA employee. Cypress will notify you if employee elects coverage.

Qualifying event (check one):	Enter required date:
☐ Termination, resignation or reduction in employee hours	Date last worked_____
☐ Death of employee	Date of death_____
☐ Divorce or legal separation	Date of divorce/separation_____
☐ Disqualification of dependent child due to attained age	Date of change in status_____
☐ Termination of domestic partnership	Date of dissolution_____
☐ Termination of Federal COBRA	End date of Federal COBRA_____
☐ Other_____	

Employer/group contact signature:_____Date_____

Employer/group contact email:_____

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Email form to enrollment@cypressadmin.com