

Cypress Dental Employee Change Request Form



GROUP NAME: _____

GROUP NUMBER: _____

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

<input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Cancel Spouse (Name): _____ <input type="checkbox"/> Cancel Child (Name): _____ <input type="checkbox"/> Cancel All Children (Names): _____ <input type="checkbox"/> Partial Cancellation (List coverages to be cancelled): _____	<input type="checkbox"/> Cancel All Coverage - Termination of Employment <input type="checkbox"/> COBRA Enrollment (Attach Election Form) <input type="checkbox"/> COBRA Termination <input type="checkbox"/> Other: _____
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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.

<u>Qualifying event (check one):</u>	<u>Enter required date:</u>
<input type="checkbox"/> Termination, resignation or reduction in employee hours	Date last worked _____
<input type="checkbox"/> Death of employee	Date of death _____
<input type="checkbox"/> Divorce or legal separation	Date of divorce/separation _____
<input type="checkbox"/> Disqualification of dependent child due to attained age	Date of change in status _____
<input type="checkbox"/> Termination of domestic partnership	Date of dissolution _____
<input type="checkbox"/> Termination of Federal COBRA	End date of Federal COBRA _____
<input type="checkbox"/> Other _____	

Employer/group contact signature: _____ Date _____

Employer/group contact email: _____

Cypress Dental
7510 Shoreline Drive
Stockton, CA 95219
800-350-3989
209-478-5614 (fax)
Email form to billing@cypressadmin.com