Employer Change Report

Missionary Church, Inc.

EMPLOYER INFORMATION

Employer name: ______________________________ Employer number: 71051

City: ______________________________ State: __________ ZIP Code: ____________________

Telephone number: (_____) ________________

Authorized representative signature:______________________________ **Date:** _____/ _____/ _____

EMPLOYEE INFORMATION: ☐ Check if address change ☐ Check if name change

Employee name: ____

Employee address:____

City: ______________________________ State: __________ ZIP Code: ____________________

Social Security number (last four digits): ____________________ Home telephone number: (________) ____________________

TYPES OF CHANGES (Must be completed for employee and/or dependents)

Effective date of change: ____/____/______

Terminations

- ☐ Terminate Employee (All coverage)
  - ☐ Continuation (requires separate form)
- ☐ Terminate Dependent
  - ☐ Continuation (requires separate form)
- ☐ Terminate a Product
- ☐ Death
- ☐ Retire

Termination Reasons (Must complete for all terminations)

- ☐ Loss of Eligibility
- ☐ No longer wants coverage
- ☐ Disability
- ☐ Death
- ☐ Other: ______________________________

Salary Change

- ☐ Salary Increase
- ☐ Salary Decrease
- ☐ New Monthly Salary (______________)

Additions

- ☐ Add a Product (Existing Employee and/or Dependent)
- ☐ Add a Dependent
- ☐ Coverage Change
- ☐ Other: ______________________________

Other Changes

- ☐ Marital Status: ______________________________
- ☐ Class Change: ______________________________
- ☐ Other: ______________________________

PRODUCT CHANGES: (Indicate coverage being added, terminated or continued by placing an X in the appropriate box.)

☐ Family life ☐ Long-term disability

Dependent information on other side

GuideStone® Insurance Plans

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DEPENDENT INFORMATION

Dependent name:______________________________ Social Security number:__________________

Relationship:______________________________ Birth date:_____/ _____/ _____ Gender: ☐ Male ☐ Female

Effective date of change:_____/ _____/ _____

Dependent name:______________________________ Social Security number:__________________

Relationship:______________________________ Birth date:_____/ _____/ _____ Gender: ☐ Male ☐ Female

Effective date of change:_____/ _____/ _____

Dependent name:______________________________ Social Security number:__________________

Relationship:______________________________ Birth date:_____/ _____/ _____ Gender: ☐ Male ☐ Female

Effective date of change:_____/ _____/ _____

Dependent name:______________________________ Social Security number:__________________

Relationship:______________________________ Birth date:_____/ _____/ _____ Gender: ☐ Male ☐ Female

Effective date of change:_____/ _____/ _____

*Your spouse and children up to age 26 are eligible for family life coverage.

INTERNAL USE ONLY

Processed by: ______________________________ Date: _____/ _____/ _____ HIPAA/PCL:__________________

Adjustments: ____

Remarks:____

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