EMI HEALTH
Smart Benefits
Formerly Educators Mutual

Change Form

Employee Name _____ T-Number _____

Change Reason _____

(Additional documentation may be requested depending on addition/deletion reason)

Addition/Deletion of Dependent

Name of Dependent _____ Relationship to Insured _____

Coverage Level of Dependent: ☐ Medical ☐ Dental ☐ Vision Gender: ☐ Male ☐ Female

Birthdate _____ Social Security Number _____

Add Date _____ OR Drop Date _____

AD&D Beneficiary Change

New Beneficiary _____ Contingent _____

Other Insurance Information Change

Insured Name _____ Policy Number _____

Insurance Company _____ Coverage Level _____

_____ _____

Employee Signature Date