Employer Change Report

Group Plans

EMPLOYER INFORMATION

Employer name: **Southern Baptist Theological Seminary** Employer number: **26045/161411**

City: **Louisville** State: **Kentucky** ZIP Code: **40280-0001**

Telephone number: (**502**) **897-4011**

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

EMPLOYEE INFORMATION

Employee name: _____

Employee address: _____

City: _____ State: _____ ZIP Code: _____

Social Security number: _____ Home telephone number: (_____) _____

☐ Check if any change of address ☐ Check if name change

TYPES OF CHANGES: INDICATE COVERAGE BEING ADDED, TERMINATED OR CONTINUED BY PLACING AN X IN THE APPROPRIATE BOX.

☐ **PA** — Partial Add. Adding coverage to an existing employee or dependent, adding a new dependent (may require a *Special and Late Applicant* form).

☐ **I** — Salary Increase.

☐ **D** — Salary Decrease.

☐ **C** — Change Coverage/Personal Data.

☐ **PT** — Partial Termination of coverage.

☐ **R** — Retire. (Requires a letter from retiree if **not** continuing coverage.)

☐ **DT** — Death. (Indicate what coverage the surviving spouse will continue.)

☐ **T** — Terminating **all** coverage. (If an employee terminates all coverage, dependent coverage will be automatically terminated.)

☐ **M** — Terminating but going on Continuation (requires separate form).

☐ **O** — Other. (Please provide explanation.) _____

All forms are on our Web site at *www.GuideStone.org*.

CHANGES IN EMPLOYEE INFORMATION

Effective date of change: _____/ _____/ _____ **Type of change:** _____ **Monthly salary: $** _____

Life volume: _____ **Optional life volume:** _____ **AD&D volume:** _____ **EPAI volume:** _____

Medical

PPO plan ☐

HRA plan ☐

Disability

Long term

☐ Choice

Dependent information on other side

GuideStone® Financial Resources

Employee name: _____ Social Security number: _____

DEPENDENT INFORMATION

Dependent name: _____ Social Security number: _____

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

Type of change: _____ Effective date: ___/___/___

Dependent name: _____ Social Security number: _____

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

Type of change: _____ Effective date: ___/___/___

Dependent name: _____ Social Security number: _____

Relationship: ☐ Child ☐ Stepchild ☐ Grandchild Birth date: ___/___/___ Gender: ☐ Male ☐ Female

Type of change: _____ Effective date: ___/___/___

Dependent name: _____ Social Security number: _____

Relationship: ☐ Child ☐ Stepchild ☐ Grandchild Birth date: ___/___/___ Gender: ☐ Male ☐ Female

Type of change: _____ Effective date: ___/___/___

Dependent name: _____ Social Security number: _____

Relationship: ☐ Child ☐ Stepchild ☐ Grandchild Birth date: ___/___/___ Gender: ☐ Male ☐ Female

Type of change: _____ Effective date: ___/___/___

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* Dependent children under age 25 are eligible for coverage if dependent is unmarried and is dependent on the employee for support and maintenance.

CHANGES IN DEPENDENT INFORMATION

Indicate coverage being added, terminated or continued by placing an X in the appropriate box.

Medical	**Life**	☐ SPAI
PPO plan ☐	☐ Spouse life	
HRA plan ☐	☐ Child life	

GUIDESTONE USE ONLY

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

Adjustments: _____

Remarks: _____

Important: To avoid additional correspondence, you should recheck this form to be sure that it has been fully completed before submitting to GuideStone.