VSP

Status Change Form
To be completed by Employee

Employee Name
_____ SSN:_____ - _____ - _____

Signature: **Date:**

Address Change
New Address**:** _____

_____

City State Zip

Employee Name Change

From: _____ To: _____

Division/Location/Plan Option Change

From: _____ To: _____

Change in Coverage

	Name	Date of Birth	Relationship To Employee	Sex
Add ☐ Delete ☐	_____	_____/_____/_____	_____	_____
Add ☐ Delete ☐	_____	_____/_____/_____	_____	_____
Add ☐ Delete ☐	_____	_____/_____/_____	_____	_____
Add ☐ Delete ☐	_____	_____/_____/_____	_____	_____
Add ☐ Delete ☐	_____	_____/_____/_____	_____	_____

☐ Terminate Coverage Date-Loss of Coverage: _____/_____/_____

To Be Completed By Employer

Employer Name: Bay County Employees Group: _____ Division: BCC

Information contained on this application regarding eligibility requirements for employee and/or dependents has been verified by the employer, Bay County Employees.

_____ _____

Employer Signature Date

Effective Date: _____/_____/_____