



EMPLOYEE CHANGES

Submit form via fax to 208-575-6423 OR request a secure email from Admin@iii-a.org.

Employee Name (Last, First)	Agency

Name, Social Security Number (SSN) or Date of Birth (DOB) Change:

Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>	
Current Name, SSN or DOB:	
New Name, SSN or DOB	

Address Change:

New Address: (Street, City, State, Zip)	
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Benefit Coverage Changes:

Add <input type="checkbox"/> Delete <input type="checkbox"/>	Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Female <input type="checkbox"/> Male <input type="checkbox"/>
Name (Last, First):		
SSN:	DOB:	
Reason for Change: (marriage, birth, open enrollment, rehired, etc.)		
Date of Qualifying Event:	Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/>	

Add <input type="checkbox"/> Delete <input type="checkbox"/>	Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Female <input type="checkbox"/> Male <input type="checkbox"/>
Name (Last, First):		
SSN:	DOB:	Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/>

Add <input type="checkbox"/> Delete <input type="checkbox"/>	Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Female <input type="checkbox"/> Male <input type="checkbox"/>
Name (Last, First):		
SSN:	DOB:	Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/>

Add <input type="checkbox"/> Delete <input type="checkbox"/>	Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/>	Female <input type="checkbox"/> Male <input type="checkbox"/>
Name (Last, First):		
SSN:	DOB:	Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/>

Prepared by:	Date:
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- Termination of employee/retiree or qualified dependent(s) may be done retroactively up to two months.
- If any claims have been incurred during the time of retroactive termination, the employee, retiree or dependent will be responsible for any amounts paid.