Employee Maintenance Form
Group Plans

RESET FORM

A. EMPLOYER INFORMATION

Employer name: _____ Employer number: 71061 International

City: Wheaton State: IL ZIP Code: 60187-0969

B. 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: (_____) _____

Marital status: ☐ Single ☐ Married

Country of destination: _____ Airport code: _____ Effective date: _____/_____/_____

C. TYPES OF CHANGES (INDICATE ALL APPROPRIATE CHANGES BY SELECTING THE APPROPRIATE BOXES.)

☐ Discontinue Coverage

Dental plans

☐ For myself
☐ For my spouse
☐ For eligible children

Coverage (check one):

☐ Premier Dental Care Plan
☐ Cigna Dental Care® DHMO Plan
HMO office ID number: _____)
☐ Cigna Global Dental Basic
☐ Cigna Global Dental Plus

Supplemental Accidental Death and Dismemberment

☐ For myself Amount: $ Select One
☐ For Affiliated Spouse Amount: $ Select One
☐ For my spouse Amount: $_____ (50%of employee volume)

Optional term life (an increase in coverage requires an Evidence of Good Health Form)

☐ For myself Amount: $ Select One
☐ For Affiliated Spouse Amount: $ Select One
☐ For my spouse Amount: $_____ (cannot exceed 50% of employee volume)

Child Life (an Evidence of Good Health Form is required)

☐ Child Life Amount: $ Select One

For dependent(s) to be covered, provide the following information:

Last name	First name	MI	Social Security number	Date of birth	Relationship	Sex M/F

Employee signature: _____ **Date:** _____/_____/_____

Employer signature: _____ **Date:** _____/_____/_____

Email to: *BenefitsHelp@Proton.me*