

**METLIFE SMALL MARKET  
CHANGE REQUEST**

GROUP NAME: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_

**TYPE OF ELIGIBILITY CHANGE: (Please list below)**

- |                         |  |   |
|-------------------------|--|---|
| 1. Name Change          | 6. Partial Cancellation (List Coverages to be Cancelled)         | 10. COBRA Enrollment (Attach Election Form) |
| 2. Address Change _____ |  | 11. COBRA Termination                       |
| 3. Cancel Spouse        | 7. Cancel All Coverage - Termination of Employment               | 12. Change Employee from DHMO to PPO*       |
| 4. Cancel 1 Child       | 8. Cancel All Contributory Coverage - Request of Active Employee | 13. Change Employee from PPO to DHMO*       |
| 5. Cancel All Children  | 9. Change Insurance Amount due to Salary Change                  | 14. Other _____                             |

**QUALIFYING EVENTS:**

**DATE:**

- |   |       |
|---|-------|
| Q1. Add Dependent – Marriage              | _____ |
| Q2. Add Dependent(s) – Birth or Adoption  | _____ |
| Q3. Add Dependent(s) – Loss of Coverage** | _____ |
| Q4. Death                                 | _____ |
| Q5. Rehired Employee                      | _____ |
| Q6. Divorce                               | _____ |

\*\* Proof of loss must be submitted with request for coverage.

Note: For requesting Facility ID code changes for DHMO business call 1-800-880-1800.

All necessary information must be included to avoid processing delays.

**COMPLETE FOR ELIGIBLE EMPLOYEE(S)**

| # | ELIGIBILITY OR QUALIFYING EVENT CHANGE | LAST NAME | FIRST NAME | SOCIAL SECURITY NUMBER | BIRTHDAY MO/DAY/YR | SEX | LIST NEW CHANGE (SALARY/ADDRESS, ETC.) | COVERAGES AFFECTED |
|---|--|-----------|------------|------------------------|--------------------|-----|--|--------------------|
|   | EFFECTIVE DATE                         |           |            |                        |                    |     |  |                    |
|   |  |           |            |                        |                    |     |  |                    |
|   |  |           |            |                        |                    |     |  |                    |
|   |  |           |            |                        |                    |     |  |                    |
|   |  |           |            |                        |                    |     |  |                    |

**COMPLETE FOR ELIGIBLE DEPENDENT(S)**

Employee's Name \_\_\_\_\_ Employee's Social Security # \_\_\_\_\_

| # | ELIGIBILITY OR QUALIFYING EVENT CHANGE | LAST NAME | FIRST NAME | BIRTHDAY MO/DAY/YR | SEX | LIST NEW CHANGE (SALARY/ADDRESS, ETC.) | COVERAGES AFFECTED |
|---|--|-----------|------------|--------------------|-----|--|--------------------|
|   | EFFECTIVE DATE                         |           |            |                    |     |  |                    |
|   |  |           |            |                    |     |  |                    |
|   |  |           |            |                    |     |  |                    |
|   |  |           |            |                    |     |  |                    |
|   |  |           |            |                    |     |  |                    |

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

EMPLOYER'S (OR REPRESENTATIVE'S) SIGNATURE \_\_\_\_\_ ( ) - \_\_\_\_\_ DATE \_\_\_\_\_

\*Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166. Dental HMO plans in CA, FL and TX are available through a domestic company in the applicable state named SafeGuard Health Plans, Inc. The SafeGuard companies are part of the MetLife family of companies.