Seattle
Department of Human Resources

# Remove Dependents from Medical, Dental and Vision Insurance

## Employee Information: (Please print)

| Last Name | First Name | Employee # or last 4-digits of SSN | Birth Date (mm/dd/yyyy) |
|---|---|---|---|
| | | | |

## Removal Reason:

Reset this section

| Qualifying Event | Date |
|---|---|
| ◯ **Termination of Marriage / Domestic Partnership** (Attach Statement of Marriage/Domestic Partnership Termination form) | Date Finalized: |
| ◯ **Legal Separation / Annulment** | Date Recorded: |
| ◯ **Death of Spouse, Domestic Partner, Child** | Date of Death: |
| ◯ **Medical Coverage Available from Other Employer** (Attach proof of other coverage if removing spouse or child) | Effective Date of Other Coverage: |
| ◯ **Other** (explain): | |

## Remove Dependent Coverage

List all eligible dependents to be removed from applicable plans. Attach list for any additional dependents.

| **Spouse / Domestic Partner** | | | | | Reset this section |
|---|---|---|---|---|---|
| Relationship | ◯ Spouse | ◯ Domestic Partner | | | |
| Last Name | First Name | MI | | | |
| | | | | | |
| **Remove from Plan** (check boxes as applicable) | ☐ Medical | ☐ Dental | ☐ Vision | | |
| **New Mailing Address** (if applicable) | | | | | |
| | Address | | City | State | Zip Code |

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| Dependent Child #1 | | | | |
|---|---|---|---|---|
| Relationship | ◯ Employee's Child<br>◯ Son ◯ Daughter | ◯ Stepchild<br>◯ Son ◯ Daughter | ◯ Domestic Partner's Child<br>◯ Son ◯ Daughter | ◯ Legal Guardian<br>◯ Son ◯ Daughter |
| Last Name | First Name | MI | | |
| | | | | |
| **Remove from Plan** (check boxes as applicable) | ☐ Medical | ☐ Dental | ☐ Vision | |
| **New Mailing Address** (if applicable) | Address | City | State | Zip |

| Dependent Child #2 | | | | |
|---|---|---|---|---|
| Relationship | ◯ Employee's Child<br>◯ Son ◯ Daughter | ◯ Stepchild<br>◯ Son ◯ Daughter | ◯ Domestic Partner's Child<br>◯ Son ◯ Daughter | ◯ Legal Guardian<br>◯ Son ◯ Daughter |
| Last Name | First Name | MI | | |
| | | | | |
| **Remove from Plan** (check boxes as applicable) | ☐ Medical | ☐ Dental | ☐ Vision | |
| **New Mailing Address** (if applicable) | Address | City | State | Zip Code |

## Acknowledgement Signature:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the insurance company. Penalties may include imprisonment, fines and denial of insurance benefits.

Employee's Signature: Date (mm/dd/yyyy):

| **Benefits Administration Use Only:** |
|---|
| Last Day of Coverage: |
| Date Entered into HRIS: |
| Refund Premiums PPE: |
| Stop After-Tax Deductions PPE: |
| Stop Imputed Income (HRIS): |
| COBRA Notice Sent: |
| Benefits Rep. Signature & Date: |