

County of Gloucester
Human Resources Manual

CHAPTER:	5 - EMPLOYEE BENEFITS	ADOPTED: 3/7/06
SECTION:	1- HEALTH BENEFITS	REVISED: 5/22/24

**EXHIBIT A – NOTICE OF CHANGE
IN MEDICAL BENEFIT OR WAIVER STATUS**

Name: _____ Department: _____

If you have any questions or need assistance completing this form, please contact Human Resources at (856) 853-3264.

1. Choose one of the following changes in your dependent(s) benefit enrollment status:

Increase in Dependent(s)

- _____ Birth or Adoption
_____ Marriage or Civil Union

Decrease in Dependent(s)

- _____ Death
_____ Divorce or Dissolution of Civil Union
_____ Dependent reached age 26
_____ Insurance available through another source

2. Date of Occurrence: _____

3. Choose one of the following coverage options to show what coverage should be in effect after the change in dependent(s) status:

- _____ Remains the same
_____ Single (Employee Only)
_____ Parent/Child (Employee & Child)
_____ Family (Employee & 2 or more dependents)
_____ Husband & Wife/Civil Union
(Employee & Spouse/Partner)

Signature: _____ Date: _____

Please complete and return to Human Resources. Thank you!