



Metropolitan Life Insurance Company, New York, NY

# METLIFE SMALL MARKET CHANGE REQUEST

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

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

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

- 1. Name Change
- 2. Address Change
- 3. Cancel Spouse
- 4. Cancel 1 Child
- 5. Cancel All Children
- 6. Partial Cancellation - (List Coverages to be Cancelled) \_\_\_\_\_
- 7. Cancel All Coverage - Termination of Employment
- 8. Cancel All Contributory Coverage – Request of Active Employee
- 9. Change Insurance Amount due to Salary Change

- 10. COBRA Enrollment (Attach Election Form)
- 11. COBRA Termination
- 12. Other \_\_\_\_\_

**QUALIFYING EVENTS:**

- 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 \_\_\_\_\_

**DATE:**

All necessary information must be included to avoid processing delays.

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

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 \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

DATE \_\_\_\_\_