

GEMSTAR CHANGE REQUEST FORM AND THE EMPLOYEE CHANGE FORM

Use these forms to notify us of a status change in coverage. A status change can be any change in a participating employee's status such as termination of an employee, change of address, marriage, divorce, death or newly acquired dependent. You may make the following changes to an employee's certificate:

- Dependent Termination or Dependent Addition
- Address Change
- Name Change
- Termination of Coverage

Complete the Change Request Form and the Employee Change Form. The Change Request Form must be signed by the employee and the Employee change Form must be signed by the employer and sent no later than 31 days following the date of the change

Submit completed forms to:

Symetra Life Insurance Company
PO Box 1064
Schenectady, NY 12301

If you have any questions concerning this form or making change to your coverage call:

(800) 561-7374 (toll free)

GemStar Group Dental Plan				Change Request Form				
Insured by: Symetra® Life Insurance Company, Bellevue, WA PO Box 1064 - Schenectady - NY - 12301 - (800) 561-7374 (toll free)								
EMPLOYER INFORMATION								
Employer Name :			Policy #:		Date of Hire:			
EMPLOYEE INFORMATION								
Reason for Change: <input type="checkbox"/> Dependent Addition <input type="checkbox"/> Dependent Termination <input type="checkbox"/> Name/Address Change <input type="checkbox"/> Termination - Reason:								
Date of Birth, Adoption, Marriage, or Other Event: _____								
Last Name		First Name		M. I.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Birth date	
Home Street Address					Home Phone ()			
City		State		Zip	Work Phone ()			
FAMILY INFORMATION List only those eligible family members who are enrolling.								
Relationship	Last Name		First Name		M. I.	Birth date	Sex	Full-Time Student?
I authorize Symetra Life Insurance Company, or its designee, to make the changes requested above. Furthermore, I authorize my employer to deduct from my paycheck any additional contribution that may be required as a result of this change throughout the term of the Policy between my employer and Symetra Life Insurance Company.								
Signature: _____						Date: _____		
Form #S10858 Rev 5/07								

SYMETRA® LIFE INSURANCE COMPANY

EMPLOYEE CHANGE FORM

EMPLOYER NAME:

GROUP #

DIVISION #

ACTION CODE (Insert Code From Below)	INSURED ID NUMBER	INSURED LAST NAME	INSURED FIRST NAME	ADDRESS OF INSURED	LAST DAY WORKED (If Applicable)	EFFECTIVE DATE OF CHANGE

Action Codes (reason for change, deletion, addition):

- A Additions (new enrollees). **Note: Plan Enrollment Cards must be attached.**
- T Termination due to decrease in hours worked. **Note: The maximum credit allowed will be three months.**
- TV Voluntary Termination. **Note: The maximum credit allowed will be three months.**
- C Correction
- AD Address Change **(Please include new address in Address of Insured box)**
- S Status Change (Marital Status, Dependent Addition, Dependent Termination, etc.) **Note: Plan Enrollment Card must be attached where applicable.**
- CC Coverage Continuation (COBRA,FMLA, etc.)

Administrator Signature: _____ Phone Number: _____ Date Completed: _____

Please return this form along with any Enrollment Cards to:
SYMETRA LIFE INSURANCE COMPANY
PO BOX 1064
SCHENECTADY, NY 12301

Questions? Please Contact: 1-800-561-7374