

University of Mississippi Benefits Information Change Form

| | | | |
|-----------------|--|-----|--|
| Name of Insured | | SSN | |
|-----------------|--|-----|--|

| Name Change/Correction: | | | |
|-------------------------|-------|------|------|
| | First | M.I. | Last |
| Current Name | | | |
| Previous Name | | | |
| Date of Change | | | |

| Address Change/Correction: | | | | |
|----------------------------|--|-------|--|-----|
| Address | | | | |
| Address | | | | |
| City | | State | | Zip |
| Home Phone | | | | |
| Office Phone | | | | |
| Date of Change | | | | |

| Marital Status Change/Correction: | |
|-----------------------------------|--|
| Date of Marriage | |
| Date of Divorce | |
| Date Widowed | |

| Family Information Change/Correction: | | | | | |
|---------------------------------------|--|-----|--|---------------|--|
| Spouse | | SSN | | Date of Birth | |
| Child | | SSN | | Date of Birth | |
| Child | | SSN | | Date of Birth | |
| Child | | SSN | | Date of Birth | |
| Child | | SSN | | Date of Birth | |
| Child | | SSN | | Date of Birth | |

| Authorization: | | | |
|----------------|--|------|--|
| Signature | | Date | |

Please circle insurances affected by this change: (please list if not included)

State Life Unum Life Dental American Heritage Cancer

Life of Alabama Cancer LTD AD&D Flexible Spending Account

Other _____