Revised
4/9/2025

BCBS_____VISION_____

Date: _____

Initials: _____

CULLMAN COUNTY COMMISSION INSURANCE
DEPENDENT CHANGE FORM (Medical/Dental/Vision)

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)			Date of Birth
Social Security Number	Department	Contract Number	Home Telephone Number ( )

DROP DEPENDENT COVERAGE

☐ Change from Family to Single Coverage

☐ Cancel dependent(s) listed below from Family Coverage

ADDITIONS – PROVIDE DOCUMENTATION

**Please read important information on the back.

☐ Change from Single to Family Coverage. Add dependent(s)**

☐ Add dependent(s) listed below to Family Coverage **

REASON FOR CANCEL — MONTH/DAY/YEAR

☐ Death _____

☐ Divorce
Attach divorce decree _____

☐ Dependent no longer eligible _____

Explain: _____

☐ Other: _____

Explain: _____

REASON FOR ADDITION — MONTH/DAY/YEAR

☐ Marriage _____

☐ Birth of Child _____

☐ Adoption of Child _____

☐ Other _____

Explain: _____

First Name Initial Last Name	Documentation is required. See back of form. Relationship to Employee		Date of Birth	Social Security Number
	☐ Male Spouse	☐ Female Spouse		
	☐ Son ☐ stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		
	☐ Son ☐ Stepson	☐ Daughter ☐ Stepdaughter		

For additional dependents, please list the information on a separate sheet and attach to this form.

TO BE COMPLETED BY EMPLOYER

Effective Date of Change: _____

Notes: _____

_____

_____

Payroll Deduction Changed To: _____

AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity, or representative acting on the Cullman County Commission's behalf.

_____

Employee Signature Date

Dependent documentation is required before dependents can be added to coverage.

GENERAL INFORMATION

Eligible Dependent
(**Appropriate documentation must be attached.)****

The term "dependent" includes the following individuals subject to appropriate documentation such as a Social Security number, marriage certificate, birth certificate, court decree, etc.

1. Your spouse (excludes divorced spouse).
2. A child under age 26, only if the child is:
    a. your son or daughter. (A court decree establishing paternity will be temporarily effective for 60 days, at which time an amended birth certificate listing the father's name will be due.)
    b. a child legally adopted by you or your spouse,
    c. your stepchild,

**Documentation Required to Add Dependents to Your Health Coverage

1. Spouse – Copy of marriage certificate, copy of spouse's social security card. (Effective 1/1/2017 common-law marriage is no longer recognized in the State of Alabama)
2. Dependent Child (under age 26) – Copy of child's birth certificate, copy of child's social security card. Copy of court order granting custody of child to you or your spouse (if applicable).

CULLMAN COUNTY COMMISSION
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CULLMAN, AL 35055

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