

Open Enrollment
Change Form Summary

Employee Name: _____

Date of Hire: _____

MEDICAL INSURANCE CHANGE

CHANGE FROM

CHANGE TO

____ Anthem Plan _____

____ Anthem Plan _____

____ Connecticare Plan _____

____ Connecticare Plan _____

____ Single

____ Single

____ Double

____ Double

____ Family

____ Family

If dependents are being removed, please provide name(s) _____

DENTAL INSURANCE CHANGE

CHANGE FROM

CHANGE TO

____ Full Plan

____ Full Plan

____ Flex Plan

____ Flex Plan

____ Single

____ Single

____ Double

____ Double

If dependents are being removed, please provide name(s) _____