The University of Mississippi

Benefits Information Change Form

Employee Name: _____

University Personnel #: _____

Effective Date: _____

Name Change/Correction

Current Name: _____
First MI Last

Previous Name: _____
First MI Last

Address Change/Correction

Address: _____
Street Address or P.O. Box

_____
City State Zip Code

Home Phone: ( ) _____-_____

According to records maintained within the Department of Human Resources you are currently enrolled in the following insurance plans. Human Resources will provide this document to the respective vendors to request the designated change be made as of the effective date indicated at the top of this form.

- (☐) State Health and Life
- (☐) American Heritage (Cancer/Dreaded Disease)
- (☐) Colonial Life & Accident Company
- (☐) Davis Vision
- (☐) Delta Dental Insurance Company
- (☐) Southern Administrators & Benefit Consultants (Flexible Spending Accounts)
- (☐) Life of Alabama (Cancer/Dreaded Disease)

_____ _____
Signature of Employee or Designee Date of Signature