Dependent Life Insurance Change Request Form

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

MetLife®

EMPLOYER NAME: The County of Ventura

POLICY NUMBER: 0154209

REASON FOR COMPLETING CHANGE REQUEST:

☐ Adding Dependent(s) - List all eligible being added
☐ Dropping Dependent(s) - List only dependent(s) to drop
☐ Updating Other Information as of: _____ (date)

Eligible Dependents who may be enrolled are:

a. Your legal spouse or domestic partner;
b. Your children from live birth up to age 26 years (a child may only be covered by one parent);
c. Your child who becomes disabled while covered under this Group Policy and is continuously disabled (incapable of self-sustaining employment and chiefly dependent upon you for support and maintenance).

EMPLOYEE INFORMATION (please print)

First name	Middle initial	Last name	Employee ID

DEPENDENT INFORMATION (please print)

Dependent's Full Name (first, middle initial, last)	**Social Security Number**	**Relationship To You**	**Living in Your Home?** (Yes/No)	**Date of Birth**

SIGNATURE REQUIRED

Employee's signature	Date signed
X	