

CHOICES

BENEFITS CHANGE FORM

Reason for Change (check below)	
<input type="checkbox"/> Marriage	<input type="checkbox"/> Loss of Employment
<input type="checkbox"/> Divorce/Legal Separation	<input type="checkbox"/> Gain of Employment
<input type="checkbox"/> Birth or Adoption	<input type="checkbox"/> Employment Status (part-time to full-time or vice versa)
<input type="checkbox"/> Death	<input type="checkbox"/> Other _____
<input type="checkbox"/> Beneficiary Change	
Date Change Occurred (Month/Day/Year) _____/_____/_____	

Part A: Employee Information

Name (Please Print)		Social Security #		
Address	City	State	Zip	Daytime Phone # ()

For each benefit, place an "X" in the box for the **NEW** benefit level and coverage you want

Part B: Change your Benefit Plan or Coverage

MEDICAL PLAN	Option: <input type="checkbox"/> \$500 Deductible <input type="checkbox"/> \$1500 Deductible <input type="checkbox"/> \$150 Deductible (limited coverage plan) <input type="checkbox"/> HMO (if you elect an HMO you must also complete an HMO application) <input type="checkbox"/> No Medical Coverage	Coverage: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One Dependent <input type="checkbox"/> Employee + 2 or More Dependents
DENTAL PLAN	Option: <input type="checkbox"/> \$25 Deductible (Full coverage) <input type="checkbox"/> \$50 Deductible (Basic coverage) <input type="checkbox"/> No Dental Coverage	Coverage: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One Dependent <input type="checkbox"/> Employee + 2 or More Dependents
EMPLOYEE LIFE INSURANCE PLAN <i>(Available only if you enroll in a Medical Option)</i>	Option: <input type="checkbox"/> Additional \$5,000 of Coverage <input type="checkbox"/> Additional \$10,000 of Coverage <input type="checkbox"/> Additional \$15,000 of Coverage <input type="checkbox"/> No Additional Coverage	
DEPENDENT LIFE INSURANCE PLAN <i>(Available only if you enroll in a Medical Option)</i>	Option: <input type="checkbox"/> Additional \$5,000 of Coverage <input type="checkbox"/> Additional \$10,000 of Coverage <input type="checkbox"/> No Dependent Life Coverage	
HEALTH CARE REIMBURSEMENT ACCOUNT	<input type="checkbox"/> ERHC - I elect to contribute \$_____ per paycheck (\$_____ annually) for the plan year to a Healthcare Reimbursement Account on a pretax basis. <input type="checkbox"/> ERDC - I elect to contribute \$_____ per paycheck (\$_____ annually) for the plan year to a Dependent Care Reimbursement Account on a pretax basis.	

Return **COMPLETED FORM** and **REQUIRED DOCUMENTS** to the Denny's Group Benefits Department.
This form cannot be processed until all required documentation is received.

EMPLOYEE SIGNATURE: _____ DATE: _____

CHOICES BENEFITS CHANGE FORM

- To make a family or employment status change, you must complete and return this form to the following address:
Denny's Corporation
Group Benefits Department P-5-10
203 East Main Street
Spartanburg, SC 29319

You may also fax this form and documentation to: (864) 597-8888.

- This form must be received by the Benefits Department within 30 calendar days of the event for which you seek a change.
- The benefit change must be consistent with your family or employment event. For example, if you get married, you may add your new spouse to your medical coverage upon your marriage.
- You must be able to verify the family or employment change. To do this, you will need to send photocopies (DO NOT SEND ORIGINALS) of the following documents (as they apply):

EVENT

- Marriage
- Birth of Child
- Adoption of Child
- Death
- Employment Change
- Divorce/Legal Separation

DOCUMENTATION

- Marriage License
- Proof of Birth
- Court Order
- Death Certificate
- Letter from Employer (HIPAA - proof of other coverage)
- Court Order granting Divorce/Legal Separation

- If you are adding or dropping dependents from your medical, dental, or life insurance coverage, you must also complete the Dependent / Beneficiary Change sections below.

Part C: Add / Drop Dependents

Add Dependent(s): This section must be completed if adding dependent(s)						Check Coverage(s) Requested for Dependents			
Dependent(s)	Relationship			Social Security Number	Date of Birth	* F/T Student	Medical	Dental	** Life
LAST NAME, FIRST NAME	Spouse	Domestic Partner	Child	000 - 00 - 0000	Mo - Day - Yr	(√)	(√)	(√)	(√)
				- -	- -				
				- -	- -				
				- -	- -				
				- -	- -				

Please attach a copy of the marriage license, birth certificate or court documentation for any dependent(s) listed with a different last name. * The age limit for f/t students is 23 (otherwise, the age limit is 19). ** Spousal or Children Life Insurance

Drop Dependent(s): (This section must be completed if dropping dependent(s))						
Dependent(s)	Relationship			Social Security Number	Date of Birth	Address
LAST NAME, FIRST NAME	Spouse	Domestic Partner	Child	000 - 00 - 0000	Mo - Day - Yr	
				- -	- -	
				- -	- -	
				- -	- -	

IF NOT RECEIVED WITHIN 30 DAYS OF THE EVENT, YOU MUST WAIT FOR THE NEXT ANNUAL ENROLLMENT PERIOD.

Part D: Name a New Beneficiary

Employee Life				
Beneficiary(ies) Name	Relationship	Date of Birth	Social Security Number	Percent (%)

I name the above beneficiary(ies) to receive any benefits from the corresponding benefit plans that may be payable in the event of my death. I understand that this designation supersedes any prior beneficiary designation. **Forms that are not fully completed will be returned.**

Employee Signature: _____

Date: _____