

# SALARIED

## BENEFITS CHANGE FORM

Reason for Change (check below)

<input type="checkbox"/> Marriage	<input type="checkbox"/> Beneficiary Change
<input type="checkbox"/> Domestic Partner Relationship	<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/from full-time)
<input type="checkbox"/> Death	<input type="checkbox"/> Other _____

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
VISION PLAN	Option: <input type="checkbox"/> Vision Coverage <input type="checkbox"/> No Vision 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	Option: <input type="checkbox"/> Additional 1 x Base Pay <input type="checkbox"/> Additional 2 x Base Pay <input type="checkbox"/> Additional 3 x Base Pay <input type="checkbox"/> Additional 4 x Base Pay <input type="checkbox"/> No Additional Coverage	SPOUSAL LIFE INSURANCE PLAN
Please note: Evidence of Insurability may be required!		<input type="checkbox"/> \$20,000 of coverage <input type="checkbox"/> \$40,000 of coverage <input type="checkbox"/> \$60,000 of coverage <input type="checkbox"/> \$80,000 of coverage <input type="checkbox"/> \$100,000 of coverage
CHILDREN'S LIFE INSURANCE PLAN	Option: <input type="checkbox"/> \$5,000 Each Child <input type="checkbox"/> \$10,000 Each Child <input type="checkbox"/> No Children Life Coverage	LONG TERM DISABILITY PLAN
Please note: Evidence of Insurability may be required!		<input type="checkbox"/> Basic Coverage (50% of Base Pay) <input type="checkbox"/> Supplemental Coverage (60% of Base Pay)
PERSONAL ACCIDENT INSURANCE PLAN	Option: <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> No Personal Accident Coverage	Coverage: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Family
FLEXIBLE SPENDING 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 Total Rewards Department.  
 This form cannot be processed until all required documentation is received.

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# SALARIED 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, vision, 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) LAST NAME, FIRST NAME	Relationship			Social Security Number 000 - 00 - 0000	Date of Birth Mo - Day - Yr	* F/T Student	Medical	Dental	Vision	** Life	Personal Accident
	Spouse	Domestic Partner	Child			(√)	(√)	(√)	(√)	(√)	(√)
				- -	- -						
				- -	- -						
				- -	- -						
				- -	- -						

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) LAST NAME, FIRST NAME	Relationship			Social Security Number 000 - 00 - 0000	Date of Birth Mo - Day - Yr	Address
	Spouse	Domestic Partner	Child	- -	- -	
				- -	- -	
				- -	- -	

**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 & Accidental Death & Dismemberment				
Beneficiary(ies) Name	Relationship	Date of Birth	Social Security Number	Percent (%)

Personal Accident				
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: \_\_\_\_\_