CHANGE FORM

EMPLOYEE DISCOUNT MEMBERSHIP
JIM DAILEY FITNESS CENTER

EMPLOYER: Pulaski County **EFFECTIVE DATE:** ___________
(To Be Completed By Human Resources)

DEPT NAME: ________________

NAME: ________________________________ **SS#:** ________________
(Please Print) **LAST** **FIRST** **MI**

TYPE OF CHANGE

Add Dependent (s) ☐
Delete Dependent (s) ☐
Terminate Coverage ☐

Add Dependent ______________________ Date Of Birth: ________________

Add Dependent ______________________ Date Of Birth: ________________

Delete Dependent(s) ____

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In signing below, I understand that by terminating coverage I cannot re-enroll for 3-months after the termination date.

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EMPLOYEE SIGNATURE **DATE**