[Date]

[Employee Name]
[Employee Address]
[City, State, Zip Code]

Subject: Benefits Enrollment Questionnaire - Life Event: Family Bereavement

Dear [Employee Name],

We extend our deepest condolences to you and your family during this difficult time. We understand that a loss in the family is a significant life event that may require adjustments to your current benefits coverage.

To assist our Benefits Department in processing your requested changes, please complete the following questionnaire and return it along with the required documentation within [Number] days of the event.

Part 1: Event Information

Name of Deceased: _____
Relationship to Employee: _____
Date of Death: _____

Part 2: Requested Changes

Please check the actions you wish to take:

- [ ] Remove deceased dependent from Medical/Dental/Vision plans
- [ ] Change Life Insurance beneficiary designations
- [ ] Adjust Tax Withholding (Form W-4)
- [ ] Update Emergency Contact information
- [ ] Other: _____

Part 3: Required Documentation

Please attach a copy of one of the following:

- Death Certificate
- Obituary or Program from Funeral Service
- Attending Physician's Statement

Employee Signature: _____

Date: _____

Please return this form to the Human Resources Department via email at [Email Address] or in person at [Office Location]. If you have any questions regarding your leave options or grief counseling services through our Employee Assistance Program (EAP), please do not hesitate to contact us.

Sincerely,

[Your Name]
[Your Title]
[Company Name]