

# Change Form

For group coverage



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Section 1

## Always complete this section:

Name \_\_\_\_\_  
Last (Sr., Jr., etc.) First MI

Residential Address \_\_\_\_\_  
Street  
City State ZIP Code + 4 County

Mailing Address \_\_\_\_\_  
if different from residential address  
Street/P.O. Box  
City State ZIP Code + 4 County

Gender  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

Social Security No. \_\_\_\_\_ Home Phone No. (\_\_\_\_)\_\_\_\_  
Area Code

Employed by \_\_\_\_\_ Work Phone No. (\_\_\_\_)\_\_\_\_  
Area Code

Member ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

**To add family members, complete this section. If your plan is a grandfathered plan, adult dependents eligible for coverage through another employee group are not eligible for coverage through this plan.**

Change to family due to:

- Birth/Adoption
- Divorce
- Open Enrollment
- Marriage
- Involuntary Loss of Coverage (Give reason) \_\_\_\_\_
- Other (Give reason) \_\_\_\_\_

<b>I want to enroll in:</b>	Health	Dental
Employee only	<input type="checkbox"/>	<input type="checkbox"/>
Employee and spouse	<input type="checkbox"/>	<input type="checkbox"/>
Employee and child(ren)	<input type="checkbox"/>	<input type="checkbox"/>
Employee and family	<input type="checkbox"/>	<input type="checkbox"/>

Date of this occurrence \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

## Spouse (complete this section if spouse is included in plan)

Name \_\_\_\_\_  
Last (Sr., Jr., etc.) First MI

Gender  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

Social Security No. \_\_\_\_\_ Date of Marriage \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

Section 2

## Dependent

Name \_\_\_\_\_  
Last (Sr., Jr., etc.) First MI

Gender  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Full Time Student?  Yes  No  
MM DD YYYY

Social Security No. \_\_\_\_\_ Relationship to employee:  Child  Stepchild  
 Legal guardian  Legal custody

## Dependent

Name \_\_\_\_\_  
Last (Sr., Jr., etc.) First MI

Gender  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Full Time Student?  Yes  No  
MM DD YYYY

Social Security No. \_\_\_\_\_ Relationship to employee:  Child  Stepchild  
 Legal guardian  Legal custody

Section 2 (cont'd)

Do you or any of your listed dependents have Medicare Parts A and/or B?  Yes  No

Name of family member with coverage:

\_\_\_\_\_  
Last (Sr., Jr., etc.) First MI

Medicare No. \_\_\_\_\_ Part A effective date \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

Part B effective date \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

Are you entitled to Medicare due to ESRD (permanent kidney failure)?  Yes  No

Is anyone enrolling in this coverage entitled to benefits for surgical, medical or dental expenses from any other group insurance (excluding Medicare, SRS, Medicaid)?  Yes  No

**To drop family members, complete this section:**

Check one:  Change to employee only  Change to employee and spouse  Change to employee and child(ren)

Retain family and terminate coverage for: \_\_\_\_\_

Divorce  Death  Other (give reason): \_\_\_\_\_

Date of occurrence \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

Section 3

Last	Name		Date of Birth		
	First	M.I.	Month	Day	Year

Section 4

**Other changes and comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I represent that all statements made herein are complete and true to the best of my knowledge. I understand that if I fail to provide any material information or if I intentionally misrepresent any material fact, such omission or intentional misrepresentation may result in the re-rating, termination or rescission of my health care coverage and/or criminal prosecution.**

To process the above changes, please sign and date:

**Your signature required**

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of group administrator \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_