

Change Form

for group coverage



Section 1 – Applicant Information (completion of this section is required)

_____ MI Gender Male Female _____ / _____ / _____
 First Name Date of Birth
 _____ Suffix _____
 Last Name Social Security Number

 Residential Address (_____) _____ - _____ (_____) _____ - _____
 Home Phone Number Cell Phone Number

 City Email Address

 State ZIP Code +4 County Employed by

 Mailing Address (if different from residential address) (_____) _____ - _____ (_____) _____ - _____
 Work Phone Number Fax Number

 City Group Number/Category

 State ZIP Code +4 County Member ID Number

Section 2 – Enrollment Information

I want to enroll in: Health Dental

Reason for change:

Open Enrollment Birth/Adoption Marriage Divorce
 Involuntary Loss of Coverage (explain) _____
 Other (give reason) _____

Official Date of Qualifying Event _____ / _____ / _____

This is not the effective date. Documentation of event may be required to complete enrollment. You will be notified if such documentation is required.

Section 2A – Adding Family Members to Coverage (please use extra sheet to add additional dependents)

Note: Complete all fields in section 2A for each dependent you wish to add.

Relationship to applicant: Spouse Child Stepchild Legal Guardianship Legal Custody

_____ MI Gender Male Female _____ / _____ / _____
 First Name Date of Birth
 _____ Suffix _____
 Last Name Social Security Number _____ / _____ / _____
 Date of Marriage/Adoption
 Type of health coverage for this dependent (check all that apply): Health Dental

Relationship to applicant: Spouse Child Stepchild Legal Guardianship Legal Custody

_____ MI Gender Male Female _____ / _____ / _____
 First Name Date of Birth
 _____ Suffix _____
 Last Name Social Security Number _____ / _____ / _____
 Date of Marriage/Adoption
 Type of health coverage for this dependent (check all that apply): Health Dental

Section 2B – Other Coverage (please use extra sheet to add additional dependents with other coverage)

Is anyone applying for this coverage enrolled in any other health insurance? Yes No

____/____/____
Other Coverage Effective Date

Name of family member with Medicare or other coverage:

First Name _____ MI

Last Name _____ Suffix

Health Carrier Name _____

ID Number _____

Dental Carrier Name _____

ID Number _____

Is anyone applying for this coverage enrolled in any other dental insurance? Yes No

____/____/____
Other Coverage Effective Date

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

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

____/____/____
Medicare Part A Effective Date

____/____/____
Medicare Part B Effective Date

Section 3 – Removing Family Members from Coverage (please use extra sheet to add additional dependents)

Check one: (please list specific members you are removing below)

- Change to employee only Change to employee and spouse Change to employee and child(ren)
- Retain family and terminate coverage for: _____

Reason for change:

- Divorce Child reaching age limit Death Other (give reason): _____

____/____/____
Official Date of Occurrence

Relationship to applicant: Spouse Child Stepchild Legal Guardianship Legal Custody

First Name _____ MI Gender Male Female _____/____/____
Date of Birth

Last Name _____ Suffix _____ Social Security Number

Relationship to applicant: Spouse Child Stepchild Legal Guardianship Legal Custody

First Name _____ MI Gender Male Female _____/____/____
Date of Birth

Last Name _____ Suffix _____ Social Security Number

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

Applicant

____/____/____
Date Signed

Plan Administrator Representative, Plan Sponsor Representative or Designated Group Contact

____/____/____
Date Signed