

# Change Form

for group coverage



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

\_\_\_\_\_  
First Name MI Gender  Male  Female \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Last Name Suffix \_\_\_\_\_  
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  Vision

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

\_\_\_\_\_  
First Name MI Gender  Male  Female \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Last Name Suffix \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Date of Marriage/Adoption \_\_\_\_\_

Type of health coverage for this dependent (check all that apply):  Health  Dental  Vision

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 \_\_\_\_\_ Date of Marriage/Adoption \_\_\_\_\_

Type of health coverage for this dependent (check all that apply):  Health  Dental  Vision

**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 Officer of the Company

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