

Employer Group Name: \_\_\_\_\_ Effective Date of Change: \_\_\_\_\_

**Employee Information**

Name: \_\_\_\_\_  
Last
First
M.I.

Address: \_\_\_\_\_

City/State/ZIP Code: \_\_\_\_\_

Employee Social Security No. or member ID no. (required): \_\_\_\_\_

New telephone no.: Home (        ) \_\_\_\_\_ Work (        ) \_\_\_\_\_

Check if name change                      Previous Name: \_\_\_\_\_

Check if new address                      Previous Address: \_\_\_\_\_

**Dependent Changes**

*When adding a dependent, you must enter Social Security Number and information about his or her primary care provider.*

CHECK ONE		NAME				BIRTH DATE			SEX	Relationship to Applicant	CHECK REASON				
ADD	REMOVE	LAST	FIRST	M.I.	MO.	DAY	YR.	F	M		Date of Marriage	Birth of Child	Date of Divorce	Return from Active Duty	Loss of Coverage
		Social Security No. _____				Primary Care Provider Name/Location _____									
		Social Security No. _____				Primary Care Provider Name/Location _____									
		Social Security No. _____				Primary Care Provider Name/Location _____									

*Adult children are eligible for coverage up to the end of the month in which they turn 26.*

**Other Health Insurance**

On the date this change will take effect, will you or any family member(s) be covered by any other group medical insurance (not replacing this plan), including Medicare?  Yes  No

*If yes, please complete this information:*

Name of person with other insurance/plan \_\_\_\_\_ Type of coverage:  Single  Family

Please list names of covered family members \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Group No. \_\_\_\_\_ Certificate No. \_\_\_\_\_

Policy: Effective date \_\_\_\_\_ Termination date \_\_\_\_\_ Will you be terminating coverage?  Yes  No

Is this a group policy/plan offered through an employer?  Yes  No If no, what is it offered through? \_\_\_\_\_

**Coverage Changes**

**Change of contract status (single, family, employee + spouse, employee + children, retirement, etc.)**  
 From \_\_\_\_\_ To \_\_\_\_\_

Change from eligible employee to state/federal continuation COBRA.  
*(Please attach copy of signed member continuation form.)*

Change from eligible dependent to state/federal continuation COBRA.  
*(Please attach copy of signed member continuation form.)*

Change of plan option (at renewal date only) \_\_\_\_\_

