

Change Form

for group coverage

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

First Name _____		MI _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> 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

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

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 _____

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