



Change Request Form

Employer Name				Group Number
Last Name	First	MI	Social Security Number	
Address	Apt No.	City	State	Zip Code
Home Telephone		Work Telephone		E-mail Address

CHANGE OF PERSONAL INFORMATION

Change my address/phone as indicated above.
 Change my name as shown above. My former name was _____

Change my Plan to: _____ Standard Plan _____ HD Option 1 _____ HD Option 2 Effective date: _____

CHANGE OF COVERAGE

Offer COBRA? Yes No ARRA Eligible? Yes No

Terminate all coverage effective _____ Reason _____

HSA Contribution Amount _____

Reinstatement all coverage effective _____ Reason _____

ADDING DEPENDENTS

Reason for Adding _____ Effective Date _____

SPOUSE				
Spouse's Full Name	Date of Marriage	Date of Birth	Social Security Number	
Employed By	Covered by other Insurance? * <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Plan	
DEPENDENTS				
Dependent's Full Name	Relationship	Sex	Date of Birth	Social Security Number
Covered by other Insurance? * <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of Plan		Is Dependent a Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent's Full Name	Relationship	Sex	Date of Birth	Social Security Number
Covered by other Insurance? * <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of Plan		Is Dependent a Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	

* If you have indicated your dependent(s) are covered under another plan, please provide a Certificate of Creditable Coverage from the prior carrier. If you have any questions regarding this information, please contact our office.

DROPPING DEPENDENTS

Dependent's Name	Effective date of change	The dependent is: <input type="checkbox"/> Deceased <input type="checkbox"/> Covered by other plan <input type="checkbox"/> Divorced <input type="checkbox"/> No longer a full-time student <input type="checkbox"/> Married <input type="checkbox"/> Exceeds minimum age <input type="checkbox"/> Other:
Relationship		
Dependent's Name	Effective date of change	The dependent is: <input type="checkbox"/> Deceased <input type="checkbox"/> Covered by other plan <input type="checkbox"/> Divorced <input type="checkbox"/> No longer a full-time student <input type="checkbox"/> Married <input type="checkbox"/> Exceeds minimum age <input type="checkbox"/> Other:
Relationship		

I understand that coverage will not become effective until approved:

Employee Signature	Date	Employer Verification / Authorized Signature	Date
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