



# 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 OF COVERAGE

For COBRA Eligible Groups: Offer COBRA? Yes No ARRA Eligible? Yes No

Terminate all Medical coverage effective \_\_\_\_\_ Reason \_\_\_\_\_  
 Terminate all Dental coverage effective \_\_\_\_\_ Reason \_\_\_\_\_  
 Reinstate all coverage effective \_\_\_\_\_ Reason \_\_\_\_\_

## ADDING DEPENDENTS

Reason for Adding: New Marriage Birth Adoption or Placement of Adoption Lost Other Coverage Other: \_\_\_\_\_

Effective Date of Change: \_\_\_\_\_

SPOUSE						
Spouse's Full Name		Date of Marriage	Date of Birth	Social Security Number	Desired Coverage: Medical Dental	
Employed By		Previously covered by other Insurance? * Yes No		If Yes, Name of Plan		
DEPENDENTS						
Dependent's Full Name		Relationship	Sex	Date of Birth	Social Security Number	Desired Coverage: Medical Dental
Previously covered by other Insurance? * Yes No		If Yes, Name of Plan		Is Dependent a Full-time Student? Yes No If Yes, provide name of institution:		
Dependent's Full Name		Relationship	Sex	Date of Birth	Social Security Number	Desired Coverage: Medical Dental
Previously covered by other Insurance? * Yes No		If Yes, Name of Plan		Is Dependent a Full-time Student? Yes No If Yes, provide name of institution:		
Dependent's Full Name		Relationship	Sex	Date of Birth	Social Security Number	Desired Coverage: Medical Dental
Previously covered by other Insurance? * Yes No		If Yes, Name of Plan		Is Dependent a Full-time Student? Yes No If Yes, provide name of institution:		

\* If you have indicated your dependent(s) were 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		The dependent is: Deceased Divorced Married	Covered by other plan No longer a full-time student Exceeds minimum age Other: _____	Desired Coverage: Medical
Relationship	Effective date of change			Dental
Dependent's Name		The dependent is: Deceased Divorced Married	Covered by other plan No longer a full-time student Exceeds minimum age Other: _____	Desired Coverage: Medical
Relationship	Effective date of change			Dental

I understand that coverage will not become effective until approved:

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ Employer Verification / Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

