

Employer Name _____ Group No. _____

Employee Name (Last Name, First, Middle Initial) _____ Social Security Number _____

Employee Address _____

City _____ State _____ Zip _____

Change address

Change my name from _____ to _____

I wish to Add coverage on myself Medical STD Dental Lost Other Coverage*

I wish to Terminate coverage on myself Medical Dental STD Date of change _____

I wish to Add coverage on my dependents Medical Dental Lost Other Coverage*

I acquired dependents by: Marriage Adoption on Date: _____

Birth Court Order

Other: Explain: _____

*Provide HIPAA certificate from Previous Insurance Carrier

I wish to Terminate coverage on my dependents Medical Dental Date of change _____

Reason for Termination: Cost

Other Coverage

Divorce

Dependent over age not a full-time student marriage

List full name of dependent(s) to be added or terminated _____ Soc Sec# _____ Date of Birth _____ Relationship _____

I certify by my signature below that there is no court or administrative order which requires any of my dependents to have health coverage.

Change of beneficiary: I hereby revoke any previous beneficiary designation and now designate the following beneficiary.

Last Name, First, Middle Initial _____ Relationship to you _____

Address of Beneficiary _____ City _____ State _____ Zip _____

Signature of Employee _____ Date of Signature _____