

SHADED AREAS TO BE COMPLETED BY EMPLOYER

NAME OF EMPLOYER		SUBGROUP CHANGE From _____ To _____		GROUP NUMBER	EFFECTIVE DATE Month Day Year		
<input type="checkbox"/> COBRA CONTINUATION	QUALIFYING EVENT	EVENT DATE		<input type="checkbox"/> 18 MONTH CONTINUATION	<input type="checkbox"/> 36 MONTH CONTINUATION		

EMPLOYEE'S LAST NAME (LEGAL NAME)	FIRST NAME	M.I.	DATE OF BIRTH Month Day Year			SOCIAL SECURITY NUMBER
STREET ADDRESS/APT. NO.					BUSINESS TELEPHONE	
CITY		STATE	ZIP	COUNTY		HOME TELEPHONE
<input type="checkbox"/> CHANGE NAME	FROM		TO			

CHANGE IN COVERAGE

CANCELLATIONS:

- Cancel all coverage
- Cancel all dependent coverage only
- Cancel coverage only on the dependent(s) listed below
- Transfer to Early Retiree group
- Transfer to Retiree group

REASON FOR CANCELLATION:

- Employee terminated
- Employee now ineligible
- Dependent now ineligible
- Last date of eligibility _____
- Moved outside area
- Dissatisfied
- Death
- Other

ADDITIONS – Add coverage on the dependent(s) listed below

REASON FOR CHANGE:

- Adoption – Date of placement/legal guardianship _____
(Placement papers must accompany this form.)
- Birth
- Married on _____
- Other _____

Will you, your spouse, and/or dependents be covered under any other health care policy as of your effective date with this policy?

YES NO If yes, name of carrier and all family members covered _____

FILL IN THE FOLLOWING INFORMATION FOR EACH PERSON AFFECTED BY THE CHANGE.

LAST NAME ONLY IF DIFFERENT FROM ABOVE	FIRST NAME	MIDDLE INITIAL	RELATIONSHIP	SEX (M or F)	DATE OF BIRTH			SOCIAL SECURITY NO.
					Month	Day	Year	

BENEFIT ELECTION: I select: Medical Coverage Dental Coverage Both For: Self Spouse Children None

Do all of the dependent(s) listed above reside at the same address as the employee? YES NO

If no, list dependent(s) name and address _____

If last name is different for dependents, please explain why _____

Are any of the above listed dependent(s) age 19 or older, full-time students? YES NO

If yes, please indicate the name, school attending and if full-time

NAME	SCHOOL	STATUS
_____	_____	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time
_____	_____	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time

I UNDERSTAND THAT PROVIDING FALSE INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

X	Month Day Year	X	Month Day Year
	SIGNATURE OF EMPLOYEE		DATE SIGNED

EMPLOYEE – COMPLETE ALL UNSHADED AREAS.