

# Change Request Form

Please use this form to request changes for currently covered members.



Employee Name (name under which currently enrolled)	Certificate Number
Employer Name	Group Number

## A. Employee Name Change (please attach documentation supporting legal name change)

Change name to: \_\_\_\_\_

## B. Address Change Change address to:

Address	City	State	Zip Code
---------	------	-------	----------

## C. Beneficiary Change

I hereby revoke any former designation of beneficiary made by me and I now designate as beneficiary:

_____	_____	_____
Name	Relationship	Social Security Number
_____	_____	_____
Name	Relationship	Social Security Number

## D. Coverage Changes (Complete applicable change section, then list all whose coverage is changing in box above signature)

**COBRA or State Continuation Request**  I wish to apply for continuation coverage for those listed below.

Date of Qualifying Event: / /	Coverage to continue: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Nature of Qualifying Event: <input type="checkbox"/> Termination ( <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary*) <input type="checkbox"/> Retirement <input type="checkbox"/> Divorce <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> No Longer Eligible <input type="checkbox"/> Other _____ *Note: If eligible for premium subsidy under ARRA, please complete form "Request for Treatment as an Assistance Eligible Employee"	

**Termination of Coverage**  I wish to terminate coverage for those listed below.

Coverages to terminate: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Date of termination: _____
Reason for termination: <input type="checkbox"/> Divorce-date of divorce _____ <input type="checkbox"/> Covered by Other Insurance <input type="checkbox"/> Other _____	

**Coverage Additions**  I wish to add coverage for those listed below.

Type of Coverage to add: <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<b>NOTE:</b> To add Medical Coverage, please complete a Group Employee Application or Dependent Addition form.
--	--

List all whose coverage is changing:

	Name (First, MI, Last)	SSN:	Sex	Birth Date	Effective Date of Change
Employee			M F	/ /	/ /
Spouse			M F	/ /	/ /
Child			M F	/ /	/ /
Child			M F	/ /	/ /
Child			M F	/ /	/ /

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date