REQUEST FOR CHANGE OF NAME, ADDRESS, BENEFICIARY OR ADDITION / CANCELLATION OF COVERAGE

I hereby request the following changes in connection with my group insurance:

EMPLOYEE NAME : (PLEASE PRINT) _____ LAST _____ FIRST _____ MIDDLE INITIAL

A. ☐ CHANGE MY NAME FROM: _____ LAST _____ FIRST _____ MIDDLE INITIAL

TO: _____ LAST _____ FIRST _____ MIDDLE INITIAL

REASON FOR CHANGE: _____

B. ☐ CHANGE MY BENEFICIARY TO: _____ LAST _____ FIRST _____ MIDDLE INITIAL

RELATIONSHIP OF BENEFICIARY TO EMPLOYEE: _____

By this request, I revoke all prior beneficiary designations.

C. ☐ ADD COVERAGE FOR: ☐ SPOUSE ONLY ☐ CHILD(REN) ONLY ☐ SPOUSE AND CHILD(REN)

D. ☐ CANCEL COVERAGE FOR: ☐ EMPLOYEE ONLY ☐ SPOUSE ONLY ☐ CHILD(REN) ONLY ☐ SPOUSE & CHILD(REN) ☐ EMPLOYEE & ALL DEPENDENTS

TYPE OF COVERAGE ADDED/CANCELED: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ LIFE ☐ OTHER _____

LIST PERSONS ADDING/CANCELING COVERAGE:
(The name, date of birth, social security number and effective date of change of each person adding or canceling coverage must be listed.)

	LAST FIRST MI	M / F	DATE OF BIRTH	SSN	A-ADD C-CANCEL	EFFECTIVE DATE OF CHANGE
EMPLOYEE						
SPOUSE						
CHILD						
CHILD						
CHILD						
CHILD						
CHILD						

REASON FOR CHANGE: _____

D. ☐ CERTIFICATE OF CREDITABLE MEDICAL COVERAGE - COMPLETE WHEN ADDING COVERAGE.

Do you or your dependents have previous creditable medical coverage under another health plan such as an employer sponsored group health plan or HMO, individual policy, Medicare, Medicaid or Champus? ☐ YES ☐ NO

If YES, a copy of any certificates of creditable medical coverage may be required prior to any claims being processed under this plan.

☐ CERTIFICATE ATTACHED ☐ CERTIFICATE BEING FORWARDED

F. CHANGE MY MAILING ADDRESS: _____ STREET

_____ TELEPHONE _____ CITY _____ STATE _____ ZIP

I understand that my election of coverages above does not automatically guarantee that coverage is in force. All eligibility requirements and of the policy(ies) must be properly satisfied before coverage becomes effective.

_____ Signature of Employee (required -except for termination of employment) _____ Social Security Number _____ Name of Employer

_____ Witness _____ Date _____ Division/Location

SUBMIT THS FORM TO HUMAN RESOURCES