Metro Atlanta Financial Group

Group number: _____ Effective Change Date: _____/____/_____

Medical Change Form

Instructions: Please complete boxes outlined in **RED.**

A: Personal Information

Last Name: _____ Middle Initial: _____ First Name: _____

Date of Birth: ____/____/____ Social Security Number: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code:_____

Home Phone Number:_____ E-mail Address: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Gender: ◯ Male ◯ Female

B: Type of Change

☐ Name Change:

Previous Name:_____

New Name: _____

☐ Address Change:

Previous Address:_____

_____

New Address: _____

_____

☐ Dependent Changes:

Dependent 1

Last Name: _____ Middle Initial: _____ First Name: _____

Date of Birth: ____/____/_____ Social Security Number: _____

Gender: ◯ Male ◯ Female ◯ Enroll ◯ Delete

Dependent 2

Last Name: _____ Middle Initial: _____ First Name: _____

Date of Birth: ____/____/_____ Social Security Number: _____

Gender: ◯ Male ◯ Female ◯ Enroll ◯ Delete

Dependent 3

Last Name: _____ Middle Initial: _____ First Name: _____

Date of Birth: ____/____/_____ Social Security Number: _____

Gender: ◯ Male ◯ Female ◯ Enroll ◯ Delete

Dependent 4

Last Name: _____ Middle Initial: _____ First Name: _____

Date of Birth: ____/____/_____ Social Security Number: _____

Gender: ◯ Male ◯ Female ◯ Enroll ◯ Delete

C: Acknowledgement of Coverage and Signature

Name Printed: _____

Signature: **X** _____ Signature Date: ___/___/____