Group number: _____

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 Tobacco Usage: ◯ Yes ◯ No

B: Type of Change [MUST SELECT OPTION(S)]

☐ **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

B: Type of Change Continued [MUST SELECT OPTION(S)]

☐ **Plan Change:**

Previous Plan Name:

New Plan Name:

☐ **Cancel Current Medical Coverage***

Cancellation Date: _____/_____/_____

*Subjected to contracted date - coverage may extend to last day of month

C: Qualifying Event Information*

Qualifying Event:

_____

_____

_____

_____

Date of Qualifying Event: _____/_____/_____

*Proof of qualifying event may be requested

D: Acknowledgement of Coverage and Signature

Name Printed:

Signature: _____ Signature Date: ____/____/_____