

# 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

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

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

## Address Change Change address to:

Address	City	State	Zip Code
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## 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

## 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: / /	Nature of Qualifying Event: <input type="checkbox"/> Termination <input type="checkbox"/> Retirement <input type="checkbox"/> Divorce <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> No Longer Eligible <input type="checkbox"/> Other _____
Coverage to continue:	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

**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.
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## 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