

CHANGE FORM

(Please print in ink)



PO Box 24042
Winston-Salem, NC 27114-4042
(336) 774-4400 Fax: (336) 760-3028
1-800-795-1023

Employer Name		Division/Location	
Employee Last Name		First Name	Middle Initial
Social Security Number	Date of Full-Time Employment (mm/dd/yyyy)		Email Address

REASON FOR ADDITION

Newborn Marriage Domestic Partner Open Enrollment Adoption (Custodial Date) _____ Other _____
(mm/dd/yyyy)

Effective Date _____
(mm/dd/yyyy)

Check the Coverage you wish to ADD

Medical for myself Dental for myself
 Medical for my dependent(s) Dental for my dependent(s)

REASON FOR CANCELLATION

Termination of Employment Leave/Payoff Open Enrollment Other _____

Last Day of Employment _____ Effective Date of Termination _____
(mm/dd/yyyy) (mm/dd/yyyy)

Check the Coverage you wish to CANCEL

Medical for myself Dental for myself
 Medical for my dependent(s) Dental for my dependent(s)

DEPENDENT INFORMATION

To be completed for all dependents (if any) being added or cancelled under this policy.

Full Name First / Middle / Last	Birthdate (mm/dd/yyyy)	Dependent SSN	Sex	Relationship	Other Coverage
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No

*Proof of full-time student status required for dependent children over the age of 19 for some dental groups. Attach a copy of paid tuition receipt and current semester schedule certificate letter (if applicable).

OTHER MEDICAL OR DENTAL COVERAGE

If other coverage (including COBRA, Medicare, or Medicaid) is still in effect, complete the information below.

Name of Insurance Company _____ Name of Policyholder _____

Relationship to Employee _____ Plan/Policy # _____ Effective Date _____
(mm/dd/yyyy)

Have you or any of the dependents you are enrolling for medical coverage under this plan been covered by another plan within 63 days before your hire date with this company? Yes No

If yes, attach a Certificate of Creditable Coverage for each person who was covered by another plan.

OTHER CHANGES

Effective Date _____
(mm/dd/yyyy)

Change of address _____ City _____ State _____ Zip _____

Name change from _____ to _____

Division/Location change from _____ to _____

Other _____

I agree that, to the best of my knowledge and belief, all statements and answers to the questions in this application are complete and true and agree that they will be the basis of the issuance of any coverage by any underwriter or carrier. Subject to the approval of this application, the benefits applied for shall become effective in accordance with the terms of my employer's health care plan document.

Employee Signature Date