CORPORATE PLAN MANAGEMENT
GROUP BENEFITS CHANGE IN STATUS FORM

Group Name: _____ Plan #: _____

Employee Social Security Number: _____

Employee Name: _____

Effective Date of Change: _____

Qualifying Event Reason:

- ☐ Marriage (please provide copy of marriage certificate)
- ☐ Birth
- ☐ Adoption or Placement of Adoption
- ☐ Loss of Previous Coverage
- ☐ Patient Protection and Affordable Care Act
- ☐ Death
- ☐ Legal Separation or Divorce (COBRA)
- ☐ Cancel Employee's Coverage(s) – Actively Employed
- ☐ Cancel dependent's (spouse/child) coverage(s)
- ☐ Reduction hours of employment (COBRA)
- ☐ Termination of Employment (COBRA) Date:_____
- ☐ Other (Please Specify Reason – retiree etc.)_____

Change In Status (Mark All That Apply):

- ☐ Name
- ☐ Address
- ☐ Change Type of Coverage
- ☐ Beneficiary
- ☐ Dependent Status (Marriage, Newborn, Divorce, etc.)

Please Give Change Information:

_____

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Please List Dependents Being Added To Plan:

Name of Family Member(s) to be Covered	Sex	Date of Birth	Social Security Number	Medical	Dental	Prescription (if applicable)
Spouse						
Child						
Child						
Child						
Child						

I hereby certify that all information on this enrollment form is true and complete; and that I am an eligible employee of the Participating Employer named above, currently working at least 30 hours per week with payroll taxes being withheld by the Participating Employer, and that I am actively at work on this date. I UNDERSTAND THAT MISSTATEMENT OR FAILURE TO DISCLOSE ANY INFORMATION MAY BE USED AS A BASIS FOR RECISSION OF COVERAGE FOR ME AND MY DEPENDENT(S). I understand that the coverage applied for will not become effective unless and until the first premium has been paid and the Company unconditionally approves and accepts the application. I authorize deductions, if any, from any earning toward the cost of coverage.

AUTHORIZATION: I hereby authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me or my dependents or my health to give to the Plan Administrator any such information. A photographic copy of this authorization shall be valid as the original.

_____ **X**_____

Signature Date — Signature of Employee

_____ **X**_____

Signature Date — Signature of Employer