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NAME OF EMPLOYER	SUBGROUP CHANGE FROM / TO	GROUP NUMBER	EFFECTIVE DATE (M/D/Y)

☐ COBRA CONTINUATION	QUALIFYING EVENT	EVENT DATE	☐ 18 MONTH CONTINUATION	☐ 36 MONTH CONTINUATION

EMPLOYEE'S LAST NAME (LEGAL NAME)	FIRST NAME	MI	DATE OF BIRTH (M/D/Y)	SOCIAL SECURITY NUMBER

☐ CHANGE ADDRESS TO:	STREET ADDRESS		APT NO.	WORK TELEPHONE (include area code)
CITY	STATE	ZIP	COUNTY	HOME TELEPHONE (include area code)

☐ **CHANGE NAME** **FROM** **TO**

CHECK TYPE OF PLAN(S) AFFECTED BY CHANGE: ☐ MEDICAL ☐ DENTAL ☐ MEDICAL AND DENTAL

☐ **CANCELLATION OF COVERAGE**

CANCELLATIONS
- ☐ Cancel all coverage
- ☐ Cancel all dependent coverage only
- ☐ Cancel coverage only on the dependent(s) listed below
- ☐ Transfer to Early Retiree group (not available to all employer groups)
- ☐ Transfer to Retiree group (not available to all employer groups)

REASONS FOR CANCELLATION
- ☐ Employee terminated
- ☐ Employee now ineligible
- ☐ Dependent now ineligible last date of eligibility________
- ☐ Moved outside of area
- ☐ Dissatisfied
- ☐ Death
- ☐ Divorce
- ☐ Other________

☐ **ADDITIONS TO COVERAGE** – Add coverage on the dependents listed below. **Indicate reason for change:**

- ☐ Adoption – date of placement / legal guardianship ________ (placement papers must accompany this form)
- ☐ Birth
- ☐ Married on ________
- ☐ Other________

DEPENDENT INFORMATION – Complete the following information for each dependent affected by the change.

LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	MI	DATE OF BIRTH (M/D/Y)	SEX (M/F)	SOCIAL SECURITY NUMBER	RELATIONSHIP

Do all dependents reside at the same address as the employee? ☐ YES ☐ NO If NO, list dependent's name and address________

If last name is different for dependent(s), please explain ________

Are any of the above dependent(s) age 19 or older, full-time students? ☐ YES ☐ NO If YES, please indicate the name of dependent, school attending and status below:

NAME	SCHOOL	STATUS	
		☐ PART-TIME	☐ FULL-TIME
		☐ PART-TIME	☐ FULL-TIME

OTHER INSURANCE INFORMATION – Failure to complete this section may result in a pre-existing condition limitation.
Do you or any family member included in this application currently have or have you (they) had any health coverage within the past 63 days? ☐ YES ☐ NO If YES, you must provide the coverage history for the past 18 months in the spaces below:

PERSON'S NAME	INSURANCE COMPANY NAME, CITY AND STATE TELEPHONE NUMBER / POLICY NUMBER	EFFECTIVE DATE	TERMINATION DATE	REASON FOR TERMINATION

I understand that providing false information or omission of relevant information in this application may result in the denial of claims or cancellation of coverage.

SIGNATURE OF EMPLOYEE (REQUIRED) DATE SIGNATURE OF EMPLOYER (OPTIONAL) DATE

FOR PLAN USE ONLY	ME	DE	SUBGROUP	COB	EFFECTIVE DATE