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)__________ (mm/dd/yyyy) ☐ Other__________

Effective Date 1/1/2021 (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__________ (mm/dd/yyyy) Effective Date of Termination __________ (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.
Policyholder: Name__________ DOB__________ Relation to Employee__________

Employer Name__________ Insurance Company Name__________ Phone__________

Effective Date__________ Plan/Policy # __________ Type of Coverage (circle): Medical Dental Vision
Type of Plan: ☐ Employer Health Plan ☐ Retiree Plan ☐ COBRA ☐ Individual Policy ☐ Medicare*
*If Medicare, provide reason for entitlement (age, disabled, ESRD, transplant): __________
Are parents of dependent children divorced, separated, or not living together? ☐ No ☐ Yes – If yes, provide the name and date of birth of the parent with primary custody:
Name__________ DOB__________
If there is a court order indicating coverage of health expenses, attach a copy for determination of benefit order.

OTHER CHANGES

Effective Date 1/1/2021

☐ 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 (mm/dd/yyyy)