

## INSTRUCTIONS TO COMPLETE THE CHANGE FORM

- Line 1** Fill in your member ID number or social security number and name. If you need a new ID card, check the "please send ID card" box.
- Line 2** If your address has changed, fill in your correct address.
- Line 3** If your name has changed, fill in your correct name and check the reason for your name change. Fill in your home phone number.
- Line 4** Fill in your correct date of birth and marital status. If you wish to cancel coverage, check the "I wish to cancel coverage" box.
- Line 5** If you desire to change your coverage, select the coverage you are choosing. If your spouse is an active or retired teacher or State employee, give your spouse's name and member ID number.
- Line 6** If you are removing or adding dependents, check "remove" or "add". If you are changing the status of a currently covered dependent child to a student, check the "change" box. Check the event that occurred that allows the change and provide the date of the event.
- Line 7** If you are removing dependents and the dependent's address is different from yours, fill in the dependent's address.
- Lines 8 through 11** If you are removing dependents, check "remove" and list the dependent's name(s) to be removed.
- If you are adding your spouse, check "add" on line 8 and provide his/her first name, middle initial, last name and social security number. Enter his/her date of birth and sex. Check "yes" or "no" to indicate whether he/she has Medicare. If "yes" is checked, complete line 13 or 14.
- If you are adding a child or children, check "add" on line 9 through 11, as applicable, and provide each eligible dependent child's name, middle initial, last name and social security number. Enter your child's date of birth, sex and relationship to you. Complete a Certification of Dependent Eligibility form for each foster child (available from your Health Benefits Representative) and attach it to this form.
- If you have a child over 19 who is a full-time student, check "student". If you have a child over 19 who is mentally or physically incapacitated, check "handicapped" and complete a Coverage Request for Mentally or Physically Incapacitated Children (available from your Health Benefits Representative) and attach it to this form.
- Check "yes" or "no" to indicate whether your child is eligible for Medicare. If "yes" is checked, complete line 13 or 14.
- If you want to change the status of a child to a student, check "change" on lines 9 through 11, as applicable, provide the child's name and complete line 12.
- Your Health Benefits Representative will complete the waiting period information.
- Line 12** If you checked "student" for any dependent child(ren) to be enrolled on lines 9 through 11, give the dependent's name and the name of the accredited institution that the dependent is attending.
- Line 13 and 14** If you, your spouse, or any of your children to be enrolled are eligible for Medicare, give the name, Medicare claim number, reason for Medicare eligibility, and the dates enrolled in Part A and Part B.
- Line 15** Complete the Prior Coverage/Other Coverage Information form (available from your Health Benefits Representative) if you or your dependents have other group health coverage in addition to the State Health Plan that will remain in effect after the effective date of this form, or if you or your dependents had other coverage that ended within the past 63 days. Attach it to this form.
- Employee Authorization** Read this statement, sign and date the form. Return the form to your Health Benefits Representative. If you have questions about this form, contact your Health Benefits Representative or Customer Service at **1-888-234-2416**.
- Your Health Benefits Representative will complete the remaining information.

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# CHANGE FORM

PLEASE TYPE OR PRINT CLEARLY IN BLUE OR BLACK INK. DO NOT WRITE IN SHADED AREAS.

1. SUBSCRIBER/MEMBER ID NO.	SOCIAL SECURITY NUMBER	LAST NAME	FIRST	INITIAL	PLEASE SEND ID CARD <input type="checkbox"/>
2. <input type="checkbox"/> CHANGE MY ADDRESS TO		STREET - ROUTE NO./BOX NO.	CITY	STATE	ZIP
3. <input type="checkbox"/> NAME CHANGE		LAST NAME	FIRST	INITIAL	BECAUSE OF <input type="checkbox"/> MARRIAGE <input type="checkbox"/> LEGAL CHANGE
4. <input type="checkbox"/> CORRECT MY BIRTHDATE TO		MO.	BIRTHDATE DATE	YEAR	<input type="checkbox"/> CHANGE MY MARITAL STATUS TO
					<input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED
5. <input type="checkbox"/> CHANGE MY COVERAGE TO		<input type="checkbox"/> EMPLOYEE ONLY	<input type="checkbox"/> EMPLOYEE-CHILD/REN	<input type="checkbox"/> EMPLOYEE-SPOUSE	<input type="checkbox"/> EMPLOYEE-FAMILY
		COMPLETE IF YOUR SPOUSE IS A TEACHER OR STATE EMPLOYEE		NAME OF SPOUSE	ID NUMBER
6. <input type="checkbox"/> REMOVE, CHANGE OR ADD DEPENDENTS		REASON AND DATE OF EVENT REQUIRED			<input type="checkbox"/> FMLA/MILITARY
<input type="checkbox"/> REMOVE		<input type="checkbox"/> MARRIAGE	___/___/___	<input type="checkbox"/> STUDENT	___/___/___
<input type="checkbox"/> CHANGE MY <input type="checkbox"/> SPOUSE		<input type="checkbox"/> SEPARATION	___/___/___	<input type="checkbox"/> NEWBORN	___/___/___
<input type="checkbox"/> ADD <input type="checkbox"/> DEPENDENT CHILD/REN		<input type="checkbox"/> DIVORCE	___/___/___	<input type="checkbox"/> STEPCILD	___/___/___
		<input type="checkbox"/> DEATH	___/___/___	<input type="checkbox"/> FOSTER CHILD	___/___/___
7. <input type="checkbox"/> REMOVE DEPENDENTS		ADDRESS (IF DIFFERENT FROM YOURS)	STREET - ROUTE NO./BOX NO.	CITY	STATE ZIP COUNTY

**DEPENDENT INFORMATION** → List dependents to be added or removed. List additional children to be added on a separate form.

	NAME (First, Middle Initial, Last)	SOCIAL SECURITY NUMBER	BIRTHDATE	SEX	CHILD IS MY	COMPLETE ONLY IF CHILD IS OVER 19	MEDICARE ELIGIBLE?	DOES WAITING PERIOD APPLY?
8. <input type="checkbox"/> REMOVE <input type="checkbox"/> ADD	SPOUSE		MONTH DAY YEAR ___/___/___	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. <input type="checkbox"/> REMOVE <input type="checkbox"/> CHANGE <input type="checkbox"/> ADD	CHILD 1		MONTH DAY YEAR ___/___/___	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> NATURAL <input type="checkbox"/> FOSTER <input type="checkbox"/> ADOPTED <input type="checkbox"/> STEP	<input type="checkbox"/> STUDENT <input type="checkbox"/> HANDICAPPED	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
10. <input type="checkbox"/> REMOVE <input type="checkbox"/> CHANGE <input type="checkbox"/> ADD	CHILD 2		MONTH DAY YEAR ___/___/___	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> NATURAL <input type="checkbox"/> FOSTER <input type="checkbox"/> ADOPTED <input type="checkbox"/> STEP	<input type="checkbox"/> STUDENT <input type="checkbox"/> HANDICAPPED	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
11. <input type="checkbox"/> REMOVE <input type="checkbox"/> CHANGE <input type="checkbox"/> ADD	CHILD 3		MONTH DAY YEAR ___/___/___	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> NATURAL <input type="checkbox"/> FOSTER <input type="checkbox"/> ADOPTED <input type="checkbox"/> STEP	<input type="checkbox"/> STUDENT <input type="checkbox"/> HANDICAPPED	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

12. IF FULL-TIME STUDENT, LIST DEPENDENT'S NAME AND ACCREDITED INSTITUTION.

**MEDICARE INFORMATION** List below yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

NAME	MEDICARE CLAIM NUMBER	ENTITLED DUE TO	EFFECTIVE DATE ENROLLED
13.		<input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> RENAL DISEASE	PART A (MM/DD/YY): ___/___/___ PART B (MM/DD/YY): ___/___/___
14.		<input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> RENAL DISEASE	PART A (MM/DD/YY): ___/___/___ PART B (MM/DD/YY): ___/___/___

15. **OTHER GROUP HEALTH COVERAGE** COMPLETE THE PRIOR COVERAGE/OTHER COVERAGE INFORMATION FORM IF YOU OR YOUR DEPENDENTS HAVE OTHER GROUP HEALTH COVERAGE IN ADDITION TO THE STATE HEALTH PLAN THAT WILL REMAIN IN EFFECT AFTER THE EFFECTIVE DATE OF THIS FORM, OR IF YOU OR YOUR DEPENDENTS HAD OTHER COVERAGE THAT ENDED WITHIN THE PAST 63 DAYS.

16. COMMENTS

**EMPLOYEE AUTHORIZATION**

I hereby apply for the changes, adjustments and/or additions to my enrollment listed on the form above and I agree that all information provided is correct. I further agree that we shall abide by the provisions of the Agreement for the selected plan option.

I hereby authorize my employer to deduct from my earnings any deduction for the coverage elected above.

DESIRED EFFECTIVE DATE OF CHANGE 01  
MONTH DAY YEAR

EMPLOYEE'S SIGNATURE \_\_\_\_\_ DATE SIGNED \_\_\_\_\_

**EMPLOYING UNIT MUST COMPLETE**

EMPLOYING UNIT NAME	EXPEDITE? <input type="checkbox"/> NO <input type="checkbox"/> YES
GROUP NO.	HIRE DATE
PAYROLL NO.	DEPARTMENT NO.
DOES MEDICARE REDUCED RATE APPLY?	<input type="checkbox"/> NO <input type="checkbox"/> YES
EMPLOYEE DEDUCTION \$	EFFECTIVE DATE
EMPLOYER CONTRIBUTION \$	<u>01</u>