

Employer Change Report

Group Plans

EMPLOYER INFORMATION

Employer name: _____ Employer number: _____

City: _____ State: _____ ZIP Code: _____

Authorized representative signature: _____ Date: ____/____/____

EMPLOYEE INFORMATION: Check if address change Check if name change

Employee name: _____

Employee address: _____

City: _____ State: _____ ZIP Code: _____

Social Security number (last four digits): _____ Home telephone number: (_____) _____

TYPES OF CHANGES (Must be completed for employee and/or dependents)

Effective date of change: ____/____/____

If employee paid for medical coverage for employee and/or dependent, please provide paid thru date. ____/____/____

Terminations

- Terminate Employee (All coverage)
 - Continuation (requires separate form)
- Terminate Dependent
 - Continuation (requires separate form)
- Terminate a Product (Employee and/or Dependent)
- Death
- Retire (If Medicare eligible complete the Sr. Plan Enrollment form)
 - Continuing coverage

Termination Reasons (Must complete for all terminations)

- Loss of Eligibility
- No longer wants coverage
- Disability
- Death
- Other: _____

Salary Change

- Salary Increase
- Salary Decrease
- New Monthly Salary (_____)

Additions (May require a Special Late Enrollment form)

- Add a Product (Existing Employee and/or Dependent)
- Add a Dependent
- Coverage Change
- Other: _____

Other Changes

- Marital Status: _____
- Class Change: _____
- Other: _____

PRODUCT CHANGES: (Indicate coverage being added, terminated or continued by placing an X in the appropriate box.)

Medical

- Health Legacy 200
- Health Today
- Health Choice 500
- Health Choice 1000
- Health Choice 2000
- Health Choice 3000
- Health Choice 5000
- Health Saver 2600
- Health Saver 2800
- Health Saver 3000

Health Select/Out-of-area

- Health Select 200
- Health Select 500
- Health Select 1000
- Health Select 2000
- Health Select 3000
- Health Select 5000

Dental

- Premier Dental Care Plan
 - Choice Dental Care Plan
 - Guided Dental HMO Plan
- Office ID number: _____

Retiree medical

- Senior Plus Plan
- Senior Plan
- Care Plus Plan
- Care Basic Plan

Life & Accident

- Life Employee
- Optional Life
- Retiree Life (volume: _____)
- Accidental Death & Dismemberment
- Employee Personal Accident (volume: _____)

Disability

- | | |
|----------------------------------|----------------------------------|
| Short term | Long term |
| <input type="checkbox"/> Premier | <input type="checkbox"/> Premier |
| <input type="checkbox"/> Choice | <input type="checkbox"/> Choice |
| <input type="checkbox"/> Economy | <input type="checkbox"/> Economy |

Dependent information on other side



Employee name: _____ Social Security number (last four digits): _____

DEPENDENT INFORMATION

Dependent name: _____ Social Security number: _____

Relationship: _____ Birth date: ____/____/____ Gender: Male Female

Effective date of change: ____/____/____ DHMO Office ID number: _____

Dependent name: _____ Social Security number: _____

Relationship: _____ Birth date: ____/____/____ Gender: Male Female

Effective date of change: ____/____/____ DHMO Office ID number: _____

Dependent name: _____ Social Security number: _____

Relationship: _____ Birth date: ____/____/____ Gender: Male Female

Effective date of change: ____/____/____ DHMO Office ID number: _____

Dependent name: _____ Social Security number: _____

Relationship: _____ Birth date: ____/____/____ Gender: Male Female

Effective date of change: ____/____/____ DHMO Office ID number: _____

*Your spouse and children up to age 26 are eligible for coverage.

DEPENDENT PRODUCT CHANGES: (Indicate coverage being added, terminated or continued by placing an X in the appropriate box.)

Medical

- Health Legacy 200
- Health Today
- Health Choice 500
- Health Choice 1000
- Health Choice 2000
- Health Choice 3000
- Health Choice 5000
- Health Saver 2600
- Health Saver 2800
- Health Saver 3000

Health Select/Out-of-area

- Health Select 200
- Health Select 500
- Health Select 1000
- Health Select 2000
- Health Select 3000
- Health Select 5000

Retiree medical

- Senior Plus Plan
- Senior Plan
- Care Plus Plan
- Care Basic Plan

Dental

- Premier Dental Care Plan
- Choice Dental Care Plan
- Guided Dental HMO Plan

Life

- Spouse life
- Spouse optional life
- Child life
- Retiree spouse life
(volume: _____)

Accident

- Spouse Personal Accident

GUIDESTONE USE ONLY

Processed by: _____ Date: ____/____/____ HIPAA/PCL: _____

Adjustments: _____

Remarks: _____