

**SMALL GROUP MEDICAL CHANGE FORM**

**PLEASE TYPE OR PRINT IN INK**  
**EMPLOYER – COMPLETE SHADED AREA AT TOP ONLY**  
**EMPLOYEE – COMPLETE ALL UNSHADED AREAS. BE SURE TO INCLUDE SOCIAL SECURITY NUMBERS.**

NAME OF EMPLOYER			GROUP NUMBER	DATE OF CHANGE
EMPLOYEE'S LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER
STREET ADDRESS / APT. NO.				
CITY		STATE	ZIP	COUNTY
				HOME TELEPHONE

**REASON FOR SUBMITTING APPLICATION**

Late Enrollment (Complete evidence form)

Adding dependent(s) (List below)

Marriage Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Other Date: \_\_\_\_\_

Deleting dependent(s) (List below)

Death Date: \_\_\_\_\_

Divorce Date: \_\_\_\_\_

Ineligible Date: \_\_\_\_\_

Other Date: \_\_\_\_\_

Name change

Former name: \_\_\_\_\_

Address change (List new address above)

Group transfer / From group: \_\_\_\_\_ To group: \_\_\_\_\_

Primary care physician change – Note person changing & new physician below

Terminate all coverage

Employee ineligible Date: \_\_\_\_\_

Terminated employment Date: \_\_\_\_\_

Death Date: \_\_\_\_\_

Moved outside service area Date: \_\_\_\_\_

Dissatisfied

Other: \_\_\_\_\_

Subscriber change\*

Spouse to spouse transfer

\*Eligible when both subscriber and spouse are full-time employees of the same employer. List new subscriber info above and dependent info below.

Re-enroll

Reason for re-enrollment \_\_\_\_\_

**COBRA AND/OR CONTINUATION**

Employee only

Family

Dependent(s) only (Complete a new enrollment form for dependents and attach to this form)

Qualifying Event: \_\_\_\_\_

Event Date: \_\_\_\_\_

**FILL IN THE FOLLOWING INFORMATION FOR EACH DEPENDENT ADDITION, CANCELLATION OR CHANGE**

LAST NAME ONLY IF DIFFERENT FROM ABOVE	FIRST NAME	M.I.	DATE OF BIRTH	SEX	SOC. SEC. NUMBER	PRIMARY CARE PHYSICIAN	PRIMARY CARE PHYSICIAN NO.
SPOUSE							
DEPENDENT							

DO ALL THE DEPENDENTS LISTED ABOVE RESIDE AT THE SAME ADDRESS AS THE EMPLOYEE?  YES  NO

IF NO, LIST DEPENDENT NAME AND ADDRESS \_\_\_\_\_

ARE ANY OF THE ABOVE DEPENDENTS AGE 19 OR OVER FULL-TIME STUDENTS?  YES  NO

IF YES, PLEASE INDICATE THE NAME, SCHOOL ATTENDING AND STATUS:

NAME	SCHOOL	STATUS	
		<input type="checkbox"/> PART-TIME	<input type="checkbox"/> FULL-TIME
		<input type="checkbox"/> PART-TIME	<input type="checkbox"/> FULL-TIME

HAVE YOU OR YOUR DEPENDENTS EVER BEEN A MEMBER OF NETWORK HEALTH PLAN?  YES  NO

DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER GROUP MEDICAL INSURANCE INCLUDING MEDICARE?  YES  NO

WHO IS THE PERSON WHO HOLDS THE OTHER INSURANCE POLICY? \_\_\_\_\_

DOES THIS OTHER POLICY INCLUDE PHARMACY COVERAGE?  YES  NO

LIST BELOW WHO IS COVERED UNDER THE OTHER GROUP MEDICAL INSURANCE, POLICY NUMBER, NAME OF COMPANY, AND EFFECTIVE DATE OF COVERAGE:

NAME OF INSURED	POLICY NUMBER	NAME OF COMPANY	EFFECTIVE DATE

APPROVED BY	UNDERWRITING	APPROVED BY	DATE APPROVED
EFFECTIVE DATE	ENTERED BY	DATE	
SHIP ACCOUNT REPRESENTATIVE SIGNATURE		DATE	

**EMPLOYEE SIGNATURE NOT REQUIRED IF CANCELLATION DUE TO TERMINATION BUT MUST BE SIGNED BY EMPLOYER.**

\_\_\_\_\_  
 SIGNATURE OF EMPLOYEE

\_\_\_\_\_  
 DATE SIGNED

\_\_\_\_\_  
 SIGNATURE OF EMPLOYER

\_\_\_\_\_  
 DATE SIGNED