

Polk County Health/Dental/Vision Insurance Change Form

Complete both Page 1 and Page 2

EMPLOYEE INFORMATION			
Name (Last, First, MI):	SSN or Employee ID #:		
Your New Name (Last, First, MI)			
Your new address (street)	(city)	(state)	(ZIP)

COMPLETE FOR ADDING, CANCELING OR CHANGING* A COVERAGE				
Coverage:				
<input type="checkbox"/> Change from Single to Family Coverage		<input type="checkbox"/> Change from Family to Single Coverage		
Health	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Employee <input type="checkbox"/> Employee	<input type="checkbox"/> Spouse <input type="checkbox"/> Spouse	<input type="checkbox"/> Children <input type="checkbox"/> Children
Dental	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Employee <input type="checkbox"/> Employee	<input type="checkbox"/> Spouse <input type="checkbox"/> Spouse	<input type="checkbox"/> Children <input type="checkbox"/> Children
Vision	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	<input type="checkbox"/> Employee <input type="checkbox"/> Employee	<input type="checkbox"/> Spouse <input type="checkbox"/> Spouse	<input type="checkbox"/> Children <input type="checkbox"/> Children

REASON FOR ADDING A COVERAGE OR DEPENDENT	
<input type="checkbox"/> marriage	<input type="checkbox"/> loss of other group coverage*
<input type="checkbox"/> other _____	<input type="checkbox"/> change in job status
	<input type="checkbox"/> birth/adoption
	<input type="checkbox"/> court order (attach a copy)
	Date of event _____
*Provide documentation from prior employer or insurance company	
	Date coverage ended _____

REASON FOR CANCELING A COVERAGE OR DEPENDENT	
<input type="checkbox"/> age limit / loss of dependent status	<input type="checkbox"/> spouse's group coverage (provide proof of other coverage)
<input type="checkbox"/> Medicare	<input type="checkbox"/> divorce (attach a copy of the First, Last and page regarding insurance benefits of the divorce decree)
<input type="checkbox"/> other _____	Date of event _____

COMPLETE FOR ADDING OR CANCELING A DEPENDENT (include last name if different from the employee)			
Spouse's name	Birth Date	Social Security number	
		<input type="checkbox"/> male <input type="checkbox"/> female	
Name(s) of child(ren)	Birth date	Social Security number	
		<input type="checkbox"/> male <input type="checkbox"/> female	
		<input type="checkbox"/> Step or Foster Child	
		<input type="checkbox"/> male <input type="checkbox"/> female	
		<input type="checkbox"/> Step or Foster Child	
		<input type="checkbox"/> male <input type="checkbox"/> female	
		<input type="checkbox"/> Step or Foster Child	

PLEASE COMPLETE THE FOLLOWING ONLY IF ADDING HEALTH INSURANCE COVERAGE

PRIMARY CARE PHYSICIAN (PCP) DESIGNATION – Each employee and member must designate a PCP before insurance cards can be generated for Health Insurance. *It is not necessary to designate a primary Dentist.*

Full Name (First, Last)	Provider Number	PCP Name (First and Last Name)	PCP Address (Location where services will be received)
<u>Spouse</u>			
<u>Dependent</u>			

OB/GYN DESIGNATION – Female members may designate an OB/GYN *in addition to a PCP*

Full Name (First, Last)	OB/GYN Provider Number	OB/GYN Name (First and Last Name)	OB/GYN Address
<u>Spouse</u>			
<u>Dependent</u>			

I understand and agree with the following statements:

- My dependents are not eligible for any coverage for which I am not covered.
- My dependents, including stepchildren, foster children and those over the maximum age, are eligible for coverage based on policy provisions. Eligibility for my dependents over the maximum age may be verified.
- If the eligibility of my dependents changes (divorce, age limit, dependent status) I will notify my employer within 31 days of the change to remove the dependent from the applicable insurance plan(s). I understand that if I fail to notify my employer, I may be held responsible for any claims paid on behalf of the ineligible dependent.
- If I cancel dental coverage, I and/or my dependents may enroll at a later date; however, enrolling late will affect the level of benefits provided.
- If the group policy requires that I make contributions, I authorize my employer to deduct them from my pay.
- If I knowingly provide false or misleading information, I may be guilty of insurance fraud, which is punishable by law.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

I declare that the information I have completed on this change form is complete and true.

Your Signature X _____ **Date Signed** _____

FOR HUMAN RESOURCE STAFF USE ONLY

Wellmark	_____	Spouse	_____
Principal Dental	_____	Dependent 1	_____
Avesis Vision	_____	Dependent 2	_____
JDEdwards	_____	Dependent 3	_____