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:

☐ **Change from Single to Family Coverage** ☐ **Change from Family to Single Coverage**

Health	☐ Add	☐ Employee	☐ Spouse	☐ Children
	☐ Cancel	☐ Employee	☐ Spouse	☐ Children
Dental	☐ Add	☐ Employee	☐ Spouse	☐ Children
	☐ Cancel	☐ Employee	☐ Spouse	☐ Children
Vision	☐ Add	☐ Employee	☐ Spouse	☐ Children
	☐ Cancel	☐ Employee	☐ Spouse	☐ Children

REASON FOR ADDING A COVERAGE OR DEPENDENT

☐ marriage ☐ loss of other group coverage* ☐ change in job status ☐ birth/adoption ☐ court order (attach a copy)

☐ other _____ Date of event _____

*Provide documentation from prior employer or insurance company Date coverage ended _____

REASON FOR CANCELING A COVERAGE OR DEPENDENT

☐ age limit / loss of dependent status ☐ spouse's group coverage (provide proof of other coverage)

☐ Medicare ☐ divorce (attach a copy of the First, Last and page regarding insurance benefits of the divorce decree)

☐ 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
		☐ male ☐ female	

Name(s) of child(ren)	Birth date		Social Security number	
		☐ male ☐ female		☐ Step or Foster Child
		☐ male ☐ female		☐ Step or Foster Child
		☐ male ☐ female		☐ Step or Foster Child
		☐ male ☐ female		☐ 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)	Current Patient?
Spouse				Yes / No
Dependent				Yes / No
Dependent				Yes / No
Dependent				Yes / No
Dependent				Yes / No

OB/GYN DESIGNATION – Female members may designate an OB/GYN *in addition to a PCP*				
Full Name (First, Last)	OB/GYN Provider #	OB/GYN Name (First and Last Name)	OB/GYN Address	Current Patient?
Spouse				Yes / No
Dependent				Yes / No
Dependent				Yes / No
Dependent				Yes / No
Dependent				Yes / No

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.
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- 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

Blues Enroll	_____	Spouse	_____
Delta Dental	_____	Dependent 1	_____
Delta Vision	_____	Dependent 2	_____
JDE - Payroll	_____	Dependent 3	_____
JDE - Dependents	_____		_____