Medical, Dental, & Vision Change Form

Requests for changes must be submitted within 31 days of Qualifying Event

Please Print Clearly

Employee Information

Worksite Employer	Employee Last Name	First Name	Date of Birth	Social Security Number	Gender

Employee Mailing Address	City	State	Zip	Phone Number

Specific Job Title	Email Address

Drop All Coverage with a Qualifying Event (**Please provide A Plus Benefits with the Letter of Creditable Coverage)

☐Health ☐Dental ☐Vision

Coverage may only be dropped due to one of the following (please select one):

☐Employee hours have dropped below 30 hours per week. Please enter date last worked full time: ____________________

☐Employee and/or dependents have obtained other group coverage**: Please enter date other coverage began: ____________________

Add Dependent(s)

Relation to Employee		List All Family Members to be Added or Dropped	Add (A) to:			M/F	DOB			Social Security Number
			Med	Den	Vis		MO	DAY	YR	
Relation to Employee Code Key:		1								
S: Spouse		2								
D: Dependent Child		3								
		4								

Due To:	*Effective Date:*	*Documentation Required:*
☐Birth of Dependent	Dependents DOB: ____________	Copy of Birth Certificate
☐Marriage	Date of Marriage: ____________	Copy of Marriage Certificate
☐Adoption of Dependent	Date Placed in Home: ____________	Copy of Adoption Papers
☐Loss of Other Group Coverage	Termination Date: ____________	Letter of Creditable Coverage with End Date

Drop Dependent(s) (not required to be completed if you have selected to Drop All Coverage above)

Relation to Employee		List All Family Members to be Added or Dropped	Drop (D) From:			M/F	DOB			Social Security Number
			Med	Den	Vis		MO	DAY	YR	
Relation to Employee Code Key:		1								
S: Spouse		2								
D: Dependent Child		3								
		4								

Due To:	*Effective Date:*	*Documentation Required:*
☐Dependent Child's Age	Dependents 26th DOB: ____________	None
☐Loss of Life	Date of Death: ____________	Copy of Death Certificate
☐Divorce	Date Divorce Final: ____________	Copy of Divorce Papers
☐Other Group Coverage	Start Date of New Coverage: ____________	Letter of Creditable Coverage with Start Date

Change of Name or Address:

Change Name To:	Change Address To:

Election To Participate

I understand the information presented to me about the plans and I have made the coverage selections represented on this form. I understand that the coverage shall become effective only in accordance with the provisions of such agreements or group policies. I understand that I must maintain 30 hours per week to remain eligible for these benefits. I authorize A Plus Benefits to make deductions from my earnings for my share of the cost, if any, of the benefits to which I may become entitled. I also understand that coverage may not be changed until Open Enrollment, or within 31 days of special enrollment situation. I understand that if I am waiving coverage for myself or any dependents that I may be eligible to enroll with a special enrollment situation, as long as I request enrollment within 31 days. I authorize EMI Health to share PHI concerning me and my family, including adult dependents, with any health care provider or HSA / HRA administrator providing benefits. I certify that the information I have provided on this form is true and complete, and that any person who includes false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

______________________________ Applicant Signature

______________________________ Date

Office Use Only

Qualifying Event:	Effective Date:	Client ID: