

## 2010 CHANGE FORM LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM SOUTHLAND NATIONAL VOLUNTARY INSURANCE

### SUBSCRIBER INFORMATION

Name (First, Middle Initial, Last)		Sex	Date of Birth
Social Security Number	Contract Number	Home Telephone Number (    )	Work Telephone Number (    )                      Ext.

Please indicate the Southland Plan that you'd like to request a change for:

Dental                       Vision                       Dental & Vision  
 (Enrollment minimum of 12 months required without qualifying status change)

**CHANGE:**    \_\_\_ MAILING ADDRESS To: \_\_\_\_\_  
                   \_\_\_ NAME From: \_\_\_\_\_ To: \_\_\_\_\_  
                   \_\_\_ E-MAIL ADDRESS To: \_\_\_\_\_

<p><b>DROP DEPENDENT COVERAGE</b> Must have a qualifying event to add/drop dependent coverage outside Open Enrollment.*</p> <p><input type="checkbox"/> Change from Family to Single Coverage  <input type="checkbox"/> Cancel dependent(s) listed below from Family Coverage</p>	<p><b>ADDITIONS – PROVIDE DOCUMENTATION</b> Must have a qualifying event to add/drop dependent coverage outside Open Enrollment.*</p> <p><input type="checkbox"/> Change from Single to Family Coverage. Add dependent(s)**  <input type="checkbox"/> Add dependent(s) listed below to Family Coverage **</p> <p style="text-align: center;">** Please read important information on the back.</p>
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<p><b>REASON FOR CANCEL</b>                      MONTH/DAY/YEAR</p> <p><input type="checkbox"/> Death    _____  <input type="checkbox"/> Divorce    _____  <input type="checkbox"/> Dependent no longer eligible _____          Explain: _____  <input type="checkbox"/> Other: _____          Explain: _____</p>	<p><b>REASON FOR ADDITION</b>                      MONTH/DAY/YEAR</p> <p><input type="checkbox"/> Marriage, date of marriage                      _____  <input type="checkbox"/> Birth or Adoption of Child                      _____  <input type="checkbox"/> Other:    _____          Explain: _____</p>
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First Name	Initial	Last Name	Relationship to Employee	Date of Birth	Social Security Number
			<input type="checkbox"/> Husband <input type="checkbox"/> Wife		
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Grandson <input type="checkbox"/> Granddaughter <input type="checkbox"/> Nephew <input type="checkbox"/> Niece		
			<input type="checkbox"/> Grandson <input type="checkbox"/> Granddaughter <input type="checkbox"/> Nephew <input type="checkbox"/> Niece		

<p><b>TO BE COMPLETED BY EMPLOYER</b></p> <p>Effective Date of Change: _____/_____/_____</p> <p>_____</p> <p style="text-align: center;">Local Government Unit Name</p> <p>_____</p> <p style="text-align: center;">Account Number</p> <p>_____</p> <p>Signature of Insurance Clerk                      Date</p>	<p><b>AFFIRMATION AND RELEASE</b></p> <p>I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity, or representative acting on the SEIB's behalf.</p> <p>_____</p> <p style="text-align: center;">Employee Signature                      Date</p>
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\* A "qualifying event" is birth, marriage, adoption, death, divorce, or otherwise losing dependent status.