9/09

# STATE EMPLOYEE'S MEMBERSHIP STATUS CHANGE

| SUBSCRIBER INFO Name (First, Middle Initial, Last) | SOCIAL SECURITY NUMBER | EFFECTIVE DATE OF CHANGE: _____ Month/Day/Year |
|---|---|---|

☐ Cancel Subscriber's coverage (part-time employees only) Date became part-time: _____

| **DROP DEPENDENT COVERAGE** **Please check appropriate box.** | | **ADDITIONS – PROVIDE DOCUMENTATION** (270-day waiting period for pre-existing conditions.) **Please check appropriate box.** | |
|---|---|---|---|
| ☐ | Change from Family to Single Coverage | ☐ | Change from Single to Family Coverage – Add Dependent(s) |
| ☐ | Cancel dependent(s) listed below from Family Coverage | ☐ | Add dependent(s) listed below to Family Coverage |
| **Reason for Cancellation:** | | ☐ | Adding Former State Employee |
| ☐ | Death (give date): | Former Employee's Social Security # | |
| ☐ | Divorce (give date) | Last work day: | |
| ☐ | Child Married (give date) | | |
| ☐ | Other (explain/give date) | | |

| **First Name Middle Initial Last Name** | **Documentation is required. Relationship to Employee** | | **Date of Birth** | **Social Security Number** |
|---|---|---|---|---|
| | ☐ **Husband** | ☐ **Wife** | | |
| | ☐ **Son** ☐ **Stepson** | ☐ **Daughter** ☐ **Stepdaughter** | | |
| | ☐ **Son** ☐ **Stepson** | ☐ **Daughter** ☐ **Stepdaughter** | | |
| | ☐ **Son** ☐ **Stepson** | ☐ **Daughter** ☐ **Stepdaughter** | | |
| | ☐ **Other Relationship** | | | |

***IMPORTANT*** If you are currently receiving a non-tobacco user premium discount, the discount will be discontinued when you add a spouse to coverage unless a new premium discount form is submitted to the SEIB. Contact your insurance clerk or the SEIB about how to apply.

## AFFIRMATION AND RELEASE

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 State's behalf.

_____ _____
Employee Signature Date

State Agency:_____

☐ Change Address To:

_____
Street Address Apartment Number

_____
City County State ZIP

(_____)_____Ext._____
Work Telephone

(_____)_____
Home Telephone