POLICY & COVERAGE CHANGE REQUEST

First Name: ______________________ Last Name: ______________________

Plan Member ID #: ______________________

Part A - Package Change Request

Current Package (check one):

☐ Signature ☐ Supreme ☐ Standard

Revised Package (check one):

☐ Signature ☐ Supreme ☐ Standard

Change to be effective on the 1st day of (month): ______________________

Reason for change request: ______________________

Part B - Health Plan Change Request

Current Health Plan (check one):

☐ Essential ☐ Essential Plus ☐ Complete ☐ Complete Plus ☐ Optimum

Revised Health Plan (check one):

☐ Essential ☐ Essential Plus ☐ Complete ☐ Complete Plus ☐ Optimum

Part C - Dental Plan Change Request

Current Dental Plan (check one):

☐ No Dental ☐ Basic Dental ☐ Enhanced Dental

Revised Dental Plan (check one):

☐ No Dental ☐ Basic Dental ☐ Enhanced Dental

Part D - Life and/or Long Term Disability Change Request

☐ Add or increase employee life insurance or long term disability
Please submit Form #3 and Form #4 in addition to this change request form

☐ Add or increase life insurance for a dependent (spouse or child)
Please submit Form #3, #4 and Form #5 (spouse) and/or Form #6 (child) in addition to this change request form

Relation	First Name	Last Name	Date of Birth	Gender

Reduce Coverage (check one):

☐ Optional Employee Life ☐ Optional Employee LTD ☐ Optional Spousal Life ☐ Optional Child Life

Remove Coverage (check one):

☐ Optional Employee Life ☐ Optional Employee LTD ☐ Optional Spousal Life ☐ Optional Child Life

For reductions, please reduce coverage to (new dollar amount): ______________________

I authorize all changes requested above to be made to my account.

Signature: ______________________ **Date:** ______________________