

Employer Name: _____

Group Number: _____

Employee Name: _____

Employee I.D. Number: _____

(Please Print)

Please complete this form to change any of the following. Please mark what change(s) you will be making:

- Section A: Add additional coverage for yourself and/or your dependents to your current policy? YES NO
- Section B: Discontinue coverage for yourself and/or your dependents? OR refuse coverage for a newly acquired dependent? YES NO
- Section C: Are you making an annual election of a High / Low Dual Health Plan? YES NO
- Section D: Has your name and/or a dependent's name changed? YES NO
- Section E: Has your address changed? YES NO
- Section F: Change your Beneficiary for your current life policy? YES NO

Section A: ADD COVERAGE (Please note, all persons must be U.S. citizens or legal aliens.)

- 1. Please check which family member(s) you are adding coverage: Employee Spouse Child(ren)
- 2. Please check type of coverage you are adding: Medical Dental Vision Life/AD&D Weekly Income
- 3. Have you and/or your dependents lost their previous health coverage within the last 30 days? YES NO

(If NO, please skip to #4)

a. Please tell us on what date the coverage has or will end: _____ / _____ / _____

- b. Please check the reason for the loss of coverage:
 - 1). Termination of Employment
 - 2). Divorce or Legal Separation of the employee
 - 3). COBRA coverage has exhausted
 - 4). Other, please explain: _____

c. Please provide the name, phone number, and I.D. number of the prior carrier: _____

- 4. Have you had a child born to you within the last 30 days? YES NO
- 5. Have you adopted a child or had a child placed with you for adoption within the last 30 days? YES NO

(If NO, please skip to #6)

a. Please provide the date of the adoption or placement, whichever is earliest: _____ / _____ / _____

b. Please attach a copy of the Order of Placement or the Decree of Adoption.

- 6. Did you get married within the last 30 days? YES NO Date married: _____ / _____ / _____

7. Please tell us about the family member(s) you are adding:

First and Last Name	Relationship	Gender	Date of Birth	Social Security Number	Does this dependent reside with you?
_____	_____	_____	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
_____	_____	_____	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
_____	_____	_____	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
_____	_____	_____	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
_____	_____	_____	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO

- ◆ If your child does not live with you, please attach a copy of your Qualified Medical Child Support Order or if you claim this child as a dependent on your Income Tax Return, please provide a copy of the most current year.
- ◆ If your dependent child has a last name that is different than yours, please attach a copy of their birth certificate.
- ◆ If your spouse has a last name that is different than yours, please attach a copy of your marriage certificate.
- ◆ **PLEASE BE ADVISED THAT THE EMPLOYEE'S SIGNATURE IS REQUIRED ON PAGE 2 OF THIS FORM.**

Section B: DISCONTINUE OR REFUSE COVERAGE

1. Please list the person(s) for which you are discontinuing or refusing coverage, then check the coverage(s) you are discontinuing or refusing for each person:

- a. _____ Medical Dental Vision Life Weekly Income All coverage
- b. _____ Medical Dental Vision Life Weekly Income All coverage
- c. _____ Medical Dental Vision Life Weekly Income All coverage
- d. _____ Medical Dental Vision Life Weekly Income All coverage
- e. _____ Medical Dental Vision Life Weekly Income All coverage
- f. _____ Medical Dental Vision Life Weekly Income All coverage

2. Please check the reason you are discontinuing or refusing coverage:

- a. Cost
- b. Other coverage
 - 1). What is the name of the other carrier? _____
 - 2). Who is the primary insured on the other coverage? _____
- c. Divorce or Legal Separation, please list the date the divorce was final: _____ / ____ / ____
- d. Dependent child is no longer eligible, please list the date dependency ended: _____ / ____ / ____
- e. Other, please explain: _____

Section C: High / Low Dual Health Plan Election

- High (better benefits, higher cost)
- Low (lesser benefits, lower cost)

Section D: NAME CHANGE

- 1. Previous Name: _____ New Name: _____
- 2. If due to marriage or divorce, please provide the date: _____ / ____ / ____

Section E: ADDRESS CHANGE

Street City State Zip

Section F: BENEFICIARY CHANGE

Last Name First Name Middle Initial Age Relationship

◆ **The Beneficiary change will not become effective until American Trust Administrators receives this form.**

I fully understand that if I should request to become covered under this plan at a later date I may be subject to a waiting period before my coverage can become effective. If my employer's group plan has dental coverage, I and/or my dependents will be considered a late applicant and dental expense benefits may be limited or nonexistent during the first 12 months that I am continuously covered under the policy. To reinstate vision coverage at a later date, I will be required to pay a fee in addition to my regular premium.

X _____

Signature of Employee Date signed

PLEASE MAIL OR FAX THIS FORM DIRECTLY TO: BENEFIT ADMINISTRATIVE SYSTEMS, LLC
FAX: 708-799-2848 17475 JOVANNA DR., STE, 1B, HOMEWOOD, IL 60430