



# CHANGE REQUEST FORM

THIS IS NOT AN APPLICATION FOR INSURANCE

BMLL Billing # \_\_\_\_\_  
 Effective Date of Change \_\_\_/\_\_\_/\_\_\_  
 Team \_\_\_\_\_  
 Carrier Group # \_\_\_\_\_  
 Employer with 20 or more employees?  Y  N

Name/Address Change  Beneficiary Change  Coverage Change  Cancel Coverage

<b>Employee</b>	<i>Last Name</i>	<i>First Name</i>	<i>M.I.</i>	<b>Social Security Number</b>
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**Employer**

**Beneficiary Change:** *I hereby revoke any current designation and change beneficiary to:*

<b>Name:</b>	<b>Relationship:</b>	<b>% of Benefit</b>
<b>Name:</b>	<b>Relationship:</b>	<b>% of Benefit</b>

**Name Change:** *(Last, First, M.I.)* *(Last, First, M.I.)*

Previous Name: \_\_\_\_\_ New Name: \_\_\_\_\_

**Address Change:**

New Address: \_\_\_\_\_

**Cancel Coverage:**  All Coverages  Medical  Dental  Vision  COBRA/State Continuation  Other

If you are terminating employment, please mark the corresponding box(es) in the section below, enter the Last Day Worked and Termination Reason

Involuntary Termination  Voluntary Termination Termination Reason: \_\_\_\_\_ Last Day Worked: \_\_\_/\_\_\_/\_\_\_

**Coverage Change** From (plan type) \_\_\_\_\_ To \_\_\_\_\_

ALL COVERAGES		MEDICAL ONLY		DENTAL ONLY		VISION ONLY		OTHER
FROM	TO	FROM	TO	FROM	TO	FROM	TO	
<input type="checkbox"/> Employee Only	<input type="checkbox"/>	<input type="checkbox"/> Employee Only	<input type="checkbox"/>	<input type="checkbox"/> Employee Only	<input type="checkbox"/>	<input type="checkbox"/> Employee Only	<input type="checkbox"/>	<input type="checkbox"/> Life/AD&D
<input type="checkbox"/> Employee & Adult	<input type="checkbox"/>	<input type="checkbox"/> Employee & Adult	<input type="checkbox"/>	<input type="checkbox"/> Employee & Adult	<input type="checkbox"/>	<input type="checkbox"/> Employee & Adult	<input type="checkbox"/>	<input type="checkbox"/> LTD
<input type="checkbox"/> Employee & Child(ren)	<input type="checkbox"/>	<input type="checkbox"/> Employee & Child(ren)	<input type="checkbox"/>	<input type="checkbox"/> Employee & Child(ren)	<input type="checkbox"/>	<input type="checkbox"/> Employee & Child(ren)	<input type="checkbox"/>	<input type="checkbox"/> STD
<input type="checkbox"/> Family	<input type="checkbox"/>	<input type="checkbox"/> Family	<input type="checkbox"/>	<input type="checkbox"/> Family	<input type="checkbox"/>	<input type="checkbox"/> Family	<input type="checkbox"/>	<input type="checkbox"/> Vol STD
<input type="checkbox"/> <b>Over 65</b>	<input type="checkbox"/>	<input type="checkbox"/> <b>Over 65</b>	<input type="checkbox"/>	<input type="checkbox"/> <b>Over 65</b>	<input type="checkbox"/>	<input type="checkbox"/> <b>Over 65</b>	<input type="checkbox"/>	<input type="checkbox"/> Vol AD&D
<input type="checkbox"/> Working <input type="checkbox"/> Retired		<input type="checkbox"/> Working <input type="checkbox"/> Retired		<input type="checkbox"/> Working <input type="checkbox"/> Retired		<input type="checkbox"/> Working <input type="checkbox"/> Retired		<input type="checkbox"/> Vol Dep Life
<input type="checkbox"/> Medicare or Complimentary to Medicare (CareFirst-Individual only; and benefit coverage only. Not eligible for HSA)	<input type="checkbox"/>	<input type="checkbox"/> Medicare or Complimentary to Medicare (CareFirst-Individual only; and benefit coverage only. Not eligible for HSA)	<input type="checkbox"/>	<input type="checkbox"/> Medicare or Complimentary to Medicare (CareFirst-Individual only; and benefit coverage only. Not eligible for HSA)	<input type="checkbox"/>	<input type="checkbox"/> Medicare or Complimentary to Medicare (CareFirst-Individual only; and benefit coverage only. Not eligible for HSA)	<input type="checkbox"/>	<input type="checkbox"/> Vol Sup Life
								<input type="checkbox"/> Vol LTD
								<input type="checkbox"/> Vol Life
								<input type="checkbox"/> Other _____
								<b>From \$</b> _____
								<b>To \$</b> _____

<p><b>QUALIFYING EVENT (REASON FOR CHANGE)</b> DATE: ___/___/___</p> <p><input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Marriage/Divorce (provide date)</p> <p><input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Medicare (provide policy information)</p> <p><input type="checkbox"/> Overage Dependent <input type="checkbox"/> Death (provide date of death)</p> <p><input type="checkbox"/> Open Enrollment</p> <p><input type="checkbox"/> Other _____</p>	<p><b>MEDICARE INFORMATION</b> (please submit copy of Medicare card)</p> <p>Medicare A Effective Date: ___/___/___</p> <p>Medicare B Effective Date: ___/___/___</p> <p>Medicare Policy Number: _____ Effective Date: _____</p> <p>Carrier: _____</p> <p>Medicare Policy #: _____ Termination Date: _____</p>
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Last,	Full First,	M.I.	Social Security Number	Birth Date	Sex	Student (Y/N)	Dis-abled (Y/N)	HMO & POS Plans: Primary Care Physician/OBGyn Provider/Dental and # (if required)	Existing Patient (Y/N)
Emp									
*Sp									
*Chd									
*Chd									

**CERTIFICATION:** I hereby certify that I am the spouse, parent or legal guardian of the dependent(s) shown above. *Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.*

**EMPLOYEE SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**EMPLOYER SIGNATURE/VERIFICATION** \_\_\_\_\_ **DATE** \_\_\_\_\_

## **SPECIAL INSTRUCTIONS** (Please print)

**BMLL Billing Number:** Please enter your BenefitMall Billing number. This can be found on your monthly invoice.

**Effective Date of Change:** Enter date (MM/DD/YY)

**Team Number:** Assigned by BenefitMall. Enter if known

**Carrier Group Number:** Enter if known

**Employer with 20 or more employees?** Mark appropriate box.

**COVERAGE CHANGES:** Select box according to Change Type.

**Name Change:** Enter complete old and new names. Last name, First name, Middle initial

**Address Change:** Enter new address only.

**Beneficiary Change:** For Life insurance purposes only.

**Cancel Coverage(s):** To cancel coverage, mark box titled "Cancel Coverage," check the line of coverage cancelling and include the *Last Day Worked* (MM/YY/DD). Check the line of coverage/type box(es) in the section below. **Checking the "Cancel Coverage" box will cancel coverage for any dependents currently covered.**

Notice of cancellation for group health (medical, dental and CareFirst BCBS vision) must be received by the last day of the month prior to the requested termination date of coverage. For example, a request to terminate coverage effective 8/1 must be received by BenefitMall no later than 7/31. If notification is received after the requested date of change, a charge may be applied up to and including the date the late notice is received. This rule also applies when removing a dependent from an active membership (i.e., spouse, coverage dependent child). Fax transmissions received after 3:00 p.m. are counted as arriving on the next business day.

### **CHANGE IN CURRENT COVERAGE -or- EMPLOYEE TERMINATION OF COVERAGE**

**Change Coverage:** To change coverage, mark box provided with the old coverage ("From") and the new coverage ("To"). If changing to a coverage that includes dependents, enter dependent information in the boxes at the bottom of the form **For medical coverage, the social security numbers are required.** Coverage changes may also require completion of a health questionnaire or other pertinent information. For "OTHER" coverage, provide the dollar amount changing From/To (if applicable).

**Example:**                      **From: Medical/Employee Only**                      **To: Medical/Family**  
   **From: Dental Employee & Spouse**                      **To: Dental/Family**

**Qualifying Event (Reason for Change):** Enter date the event took place (MM/YY/DD) and select the event type. If "Other," mark box and write in Qualifying Event. Documentation may be required. Please refer to your carrier guidelines for more information.

**Medicare Information:** Enter Medicare information and submit a copy of your Medicare card along with this form.

**Dependent Information:** If adding coverage for dependents, complete all the information in the space provided, including the name of the Primary Care Physician, OB/GYN and/or Dentist (if applicable).

**Signature:**                      Employee and Employer must sign and date the form.