3PADMINISTRATORS

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EMPLOYER GROUP: __MILLIS TRANSFER__

For Office Use Only
Effective: _____
Group ID: _____

CHANGE REQUEST FORM

Employee Name:_____ **SSN:**_____

Type of Change Requested:
- ☐ Name Change
- ☐ Address Change
- ☐ Add Dependents
- ☐ Remove Dependents
- ☐ Coverage Change

Reason for Change (include date of occurrence):
- ☐ Birth or Adoption _____
- ☐ Marriage _____
- ☐ Divorce_____
- ☐ Loss of eligibility _____
- ☐ No longer needed_____
- ☐ Loss of other insurance_____
- ☐ Other (provide information below)

Name Change:

Previous name:_____ New name:_____

Address Change:

Old address:_____

New address:_____

Add Dependents:

Name:_____ Relationship:_____ Date of birth:_____ SSN:_____
Name:_____ Relationship:_____ Date of birth:_____ SSN:_____
Name:_____ Relationship:_____ Date of birth:_____ SSN:_____

If additional space is needed, please use back side of this form.
If any dependents have other insurance, please identify policy:_____

Remove Dependents:

Name:_____ Reason:_____ Date of birth:_____
Name:_____ Reason:_____ Date of birth:_____
Name:_____ Reason:_____ Date of birth:_____

If additional space is needed, please use back side of this form.

Change Coverage:

Current coverage:
- ☐ Single Medical
- ☐ Single Dental
- ☐ Single Vision
- ☐ Family Medical
- ☐ Family Dental
- ☐ Family Vision

Change request:
- ☐ Single Medical
- ☐ Single Dental
- ☐ Single Vision
- ☐ Family Medical
- ☐ Family Dental
- ☐ Family Vision
- ☐ None (terminate coverage)

Other:

Please identify your change request:_____

I certify that the above information is true and correct to the best of my knowledge. I understand that if I am terminating coverage, I may not be able to get back on the plan at a later date unless a Special Enrollment situation occurs.

_____ _____
Employee Signature Date

- FORM MUST BE SUBMITTED WITHIN 30 DAYS OF THE CHANGE -