

Section 1

Group No.	Health/Life Subscriber No. if applicable				
Primary Insured Last Name	First	Middle			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address — No. and Street Name	<input type="checkbox"/> Check only if address has changed	City	State	ZIP	Home Telephone No. ()
E-mail Address					Work Telephone No. ()
					Cell Telephone No. ()

Section 2 — Check Applicable Box(es)

<input type="checkbox"/> Change My Name To:	Check reason and show effective date	
	<input type="checkbox"/> Married ____/____/____	<input type="checkbox"/> Divorced ____/____/____ <input type="checkbox"/> Other ____/____/____
<input type="checkbox"/> Add Coverage	Date: ____/____/____	
<input type="checkbox"/> Cancel Coverage		

Section 3 — Complete All Information for Each Dependent Being Added or Dropped

(1) A child of the member's child can be listed as a dependent, only if IRS guidelines are met.
 (2) Stepchildren can be listed as dependents.
 (3) A child can be listed if a participant receives a court order to cover that child. Your employer will supply a separate form for those dependents.
 (4) When other than a natural or adopted child, or a court ordered dependent child, is listed as a dependent, they must meet IRS guidelines and the member's address must be their primary address.
 (5) If adding a disabled child who exceeds the age limit in your Association's contract, complete the Over-age Dependent Information in Section 4.
 (6) Add or drop dependent.

Premium Plan Select Plan

List full name of all dependents to be covered <input type="checkbox"/> Husband <input type="checkbox"/> Wife	Social Security Number -	Date of Birth Mo Day Yr	Height	Weight	Select Dependent Coverage Health Dental <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Complete ONLY if different from employee's address	Number and Street Name	City	State	ZIP	
List full name of all dependents to be covered <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Social Security Number -	Date of Birth Mo Day Yr	Height	Weight	Select Dependent Coverage Health Dental <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Complete ONLY if different from employee's address	Number and Street Name	City	State	ZIP	
List full name of all dependents to be covered <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Social Security Number -	Date of Birth Mo Day Yr	Height	Weight	Select Dependent Coverage Health Dental <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
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List full name of all dependents to be covered <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Social Security Number -	Date of Birth Mo Day Yr	Height	Weight	Select Dependent Coverage Health Dental <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Complete ONLY if different from employee's address	Number and Street Name	City	State	ZIP	

