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

Employee *Last Name* *First Name* *M.I.*	**Social Security Number**
Employer	

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

Name:	**Relationship:**	**% of Benefit**
Name:	**Relationship:**	**% of Benefit**

☐ 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**	
☐ Employee Only	☐	☐ Employee Only	☐	☐ Employee Only	☐	☐ Employee Only	☐	☐ Life/AD&D
☐ Employee & Adult	☐	☐ Employee & Adult	☐	☐ Employee & Adult	☐	☐ Employee & Adult	☐	☐ LTD
☐ Employee & Child(ren)	☐	☐ Employee & Child(ren)	☐	☐ Employee & Child(ren)	☐	☐ Employee & Child(ren)	☐	☐ STD
☐ Family	☐	☐ Family	☐	☐ Family	☐	☐ Family	☐	☐ Vol STD
☐ **Over 65**	☐	☐ **Over 65**	☐	☐ **Over 65**	☐	☐ **Over 65**	☐	☐ Vol AD&D
☐ Working ☐ Retired		☐ Working ☐ Retired		☐ Working ☐ Retired		☐ Working ☐ Retired		☐ Vol Dep Life
☐ Medicare or Complimentary to Medicare (CareFirst-Individual only; and benefit coverage only. Not eligible for HSA)	☐	☐ Medicare or Complimentary to Medicare (CareFirst-Individual only; and benefit coverage only. Not eligible for HSA)	☐	☐ Medicare or Complimentary to Medicare (CareFirst-Individual only; and benefit coverage only. Not eligible for HSA)	☐	☐ Medicare or Complimentary to Medicare (CareFirst-Individual only; and benefit coverage only. Not eligible for HSA)	☐	☐ Vol Sup Life ☐ Vol LTD ☐ Vol Life ☐ Other_____ **From $ _____** **To $_____**

QUALIFYING EVENT (REASON FOR CHANGE)
DATE: __ __ /__ __ / __ __

☐ Loss of Coverage
☐ Birth/Adoption
☐ Overage Dependent
☐ Open Enrollment
☐ Other _____
☐ Marriage/Divorce (provide date)
☐ Medicare (provide policy information)
☐ Death (provide date of death)

MEDICARE INFORMATION (please submit copy of Medicare card)

Medicare A Effective Date: __ __ / __ __ / __ __
Medicare B Effective Date: __ __ / __ __ / __ __
Medicare Policy Number: Effective Date:
Carrier:
Medicare Policy #: Termination Date:

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/YY/DD)

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, overage 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.