KELLY & ASSOCIATES INSURANCE GROUP, INC.

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EXISTING MEMBER TERMINATION / CHANGE FORM

Please print clearly in CAPITAL letters **Please fill in the circles completely** ●

1 GENERAL INFORMATION

Company Name			KELLY Company ID#
Last Name	First Name	MI	Title (Jr., III, etc.)
Social Security#	Date of Birth (MM-DD-YY)	Employer Phone#	

2 EMPLOYEE TERMINATION OF COVERAGE

○ Terminate ALL Active Lines of Coverage ○ Health ○ Vision ○ Vol. Life ○ Vol. Sp. Life ○ STD ○ LTD ○ Suppl. Life/AD&D ○ Dental ○ Life/AD&D ○ Vol. AD&D ○ Vol. Dep. Life ○ Vol. STD ○ Vol. LTD

Reason for Termination:
○ Death of Employee ○ Loss of Dependent Status ○ Non-Payment of COBRA Premium
○ Employment Status Change ○ Enrollment in Medicare ○ Dropping Coverage Voluntarily ○ Gain of Other Coverage
○ End of Employment ○ Reduction in Hours ○ Court Ordered Cancellation ○ Not Eligible ○ Other: _____

Qualifying Event Date:
Coverage Term Date:

3 CHANGE IN CURRENT COVERAGE LEVEL

MEDICAL ONLY		DENTAL ONLY		VISION ONLY		ALL LINES		OTHER Plan _____	
FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
○ Employee Only	○	○ Employee Only	○	○ Employee Only	○	○ Employee Only	○	○ Employee Only	○
○ Employee & 1 Child	○	○ Employee & 1 Child	○	○ Employee & 1 Child	○	○ Employee & 1 Child	○	○ Employee & 1 Child	○
○ Employee & Spouse	○	○ Employee & Spouse	○	○ Employee & Spouse	○	○ Employee & Spouse	○	○ Employee & Spouse	○
○ Family	○	○ Family	○	○ Family	○	○ Family	○	○ Family	○

Qualifying Event : ○ Marriage ○ Newborn / Adoption ○ Loss of Coverage

Qualifying Event Date: ___/___/___

Requested Date of Change: ___/___/___

Last, Full First, M.I.	Social Security #	Birth Date	Sex (M/F)	F/T Student (Y/N)*	Disabled (Y/N)	*POS or HMO only:* Line 1: PCP Info; Line 2: OB/GYN Info — Physician Name	Physician #	Existing Patient (Y/N)
Sp								
Chd								
Chd								
Chd								

*If full time student, please submit proper form, or appropriate verification of student status (e.g. class schedule, statement from Registrar's office, cancelled check)

Are you or any of your dependents eligible for Medicare? If Yes: Effective Date (Part A) ___/___/___ Effective Date (Part B) ___/___/___

4 MISCELLANEOUS CHANGES

Name Change : From:_____ To:_____

Address Change: From:_____ To:_____

Telephone Number Change: From: ( ) _____ To: ( ) _____

Salary Change: From: $_____ To: $_____ Effective Date of Change: ___/___/___

Provider Change: ○ PCP ○ OB/GYN ○ DENTIST Change for all members?: ○ Y ○ N If no, list member name:_____

From: _____ # _____ To: _____ # _____ Existing Patient: ○ Y ○ N

Medicare: ○ Add ○ Drop

Name:_____ Medicare ID #:_____ Part A: ___/___/___ Part B: ___/___/___

Beneficiary Change- Life Insurance: I am changing my group term Life Insurance beneficiary(s) (Please print full name including middle initial)

Primary To:_____ Relationship:_____

Secondary To:_____ Relationship:_____

5

EMPLOYEE SIGNATURE _____ DATE ___/___/___

EMPLOYER SIGNATURE / VERIFICATION _____ DATE ___/___/___

Note: Form invalid without required signatures

1.26.11