



Assured Benefits Administrators  
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# Change Request Form

Department \_\_\_\_\_ Member ID Number \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_ Apt No. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_ E-mail Address \_\_\_\_\_

### CHANGE OF PERSONAL INFORMATION

Change my address/phone as indicated above.  Change my name as shown above. My former name was \_\_\_\_\_

### CHANGE OF COVERAGE

Offer COBRA?  Yes  No

Terminate all coverage effective \_\_\_\_\_ Reason \_\_\_\_\_

Terminate HSA Contributions effective \_\_\_\_\_ Reason \_\_\_\_\_

HSA Contribution Amount \_\_\_\_\_

Reinstate all coverage effective \_\_\_\_\_ Reason \_\_\_\_\_

My NEW Plan elections are: Effective date: \_\_\_\_\_

COVERAGE ENROLLMENT LEVEL:	<input type="checkbox"/> SINGLE	<input type="checkbox"/> EE + SPOUSE	<input type="checkbox"/> EE + CHILDREN	<input type="checkbox"/> FAMILY	<input type="checkbox"/> I DO NOT WISH TO ENROLL
MEDICAL PLAN SELECTION:	<input type="checkbox"/> TRADITIONAL PLAN	<input type="checkbox"/> BASIC PLAN	<input type="checkbox"/> HD PLAN	<input checked="" type="checkbox"/> DENTAL & VISION-AUTOMATIC WITH MEDICAL ENROLLMENT	

### ADDING DEPENDENTS

**If you are adding a dependent spouse or child, this change form must be submitted to the City of Moore benefits office within 30 days of the date of marriage, birth, adoption, or loss of coverage.**

Reason for Adding \_\_\_\_\_ Effective Date \_\_\_\_\_

SPOUSE						
Spouse's Full Name		Date of Marriage	Date of Birth	Social Security Number		
Employed By		Covered by other Insurance, Medicare or COBRA? * (Please include a copy of the ID card) <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, Name of Plan	
Group Number		ID Number	Effective Date			
Health Plan Address		City	State	Zip Code	Phone Number	
DEPENDENTS						
Dependent's Full Name		Relationship	Sex	Date of Birth	Social Security Number	
Employed By		Is dependent eligible for Insurance through their employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Covered by other Insurance, Medicare or COBRA? * (Please include a copy of the ID card) <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, Name of Plan
Group Number		ID Number	Effective Date			
Health Plan Address		City	State	Zip Code	Phone Number	
Dependent's Full Name		Relationship	Sex	Date of Birth	Social Security Number	
Employed By		Is dependent eligible for Insurance through their employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Covered by other Insurance, Medicare or COBRA? * (Please include a copy of the ID card) <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, Name of Plan
Group Number		ID Number	Effective Date			
Health Plan Address		City	State	Zip Code	Phone Number	

\* If you have indicated your dependent(s) are covered under another plan, please provide a copy of the ID card or a Certificate of Creditable Coverage from the prior carrier. If you have any questions regarding this information, please contact our office.

**DROPPING DEPENDENTS****If you are dropping a dependent spouse or child, this change form must be submitted to the City of Moore benefits office within 30 days of the date of divorce, death, or other change in coverage.**

Dependent's Name		<b>The dependent is:</b> <input type="checkbox"/> Deceased <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Covered by other plan <input type="checkbox"/> Exceeds minimum age <input type="checkbox"/> Other: _____
Relationship	Effective date of change	
Dependent's Name		<b>The dependent is:</b> <input type="checkbox"/> Deceased <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Covered by other plan <input type="checkbox"/> Exceeds minimum age <input type="checkbox"/> Other: _____
Relationship	Effective date of change	
Dependent's Name		<b>The dependent is:</b> <input type="checkbox"/> Deceased <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Covered by other plan <input type="checkbox"/> Exceeds minimum age <input type="checkbox"/> Other: _____
Relationship	Effective date of change	

I understand that these changes will not become effective until approved:

Employee Signature

Date

Employer Verification / Authorized Signature

Date