Change of Status

FORM

LAST NAME		FIRST NAME	M.I.
ADDRESS CHANGE: ☐ (YES) MAILING ADDRESS		EMAIL ADDRESS	
SEX	MARITAL STATUS	DOB (MM/DD/YY)	MEMBER ID NO/ SOCIAL SECURITY NO.
EMPLOYER		WORK PHONE (INCL. EXT.)	CELL PHONE

I. DEPENDENT CHANGES

Note: All additions must be made within 30 days of the date your dependent becomes eligible or during the enrollment period of your group. Dependents become eligible on their date of birth, date of marraige, or date of adoption. Supporting documents will be required to enroll dependents with a different last name, common-law spouse, stepchildren, legal guardians and children over the age limit as specified by your group contract. Please note that certain dependent relationships may not be recognized by your group plan. For dependents being added outside the open enrollment period, please complete a Part II form.

ADD	DELETE	LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SOCIAL SECURITY NUMBER	BIRTHDATE	SEX M F
☐	☐							
☐	☐							
☐	☐							

If spouse being added, please indicate spouse's Employer. ____________________

Name of previous Health Plan: ____________ Effective Date: ____________ Termination Date: ____________

II. CLASS CHANGE

☐ Medical change from ____________ to ____________ Effective Date: ____________

☐ Medical and Dental change from ____________ to ____________ Effective Date: ____________

III. MISCELLANEOUS CHANGE

☐ Name* change from ____________ to ____________

☐ Date of Birth* change from ____________ to ____________

☐ Plan change from ____________ to ____________

☐ Transfer to COBRA Effective Date: ____________

☐ Add ☐ Delete Dental Coverage Effective Date: ____________ Dental coverage can only be added/deleted during the Open Enrollment period.

* Supporting documents will be required to complete the change request.

Transferring of plans includes current dependents and class. If any other changes apply, please mark the appropriate boxes above such as adding/deleting dependents or class change.

IV. CANCEL COVERAGE

☐ Cancel MEDICAL coverage for the entire family. Effective Date: ____________

Reason for cancellation: ____________ Medical coverage can only be deleted during the Open Enrollment period.

I confirm that I have read the eligibility requirements stated in the brochure and attest that all dependents meet these requirements. I agree to provide StayWell Insurance with all documents necessary to support eligibility. I understand that StayWell Insurance has the right to request additional documents at any time after enrollment. I understand that failure to submit these required documents may result in a loss of coverage at the discretion of StayWell Insurance. Should this occur, I understand and agree I may be responsible for the costs of all health care provided to me and my dependents. I understand that approving coverage does not constitute acceptance of eligibility by StayWell Insurance until I provide all requested documents.

____________________ EMPLOYEE'S SIGNATURE

____________________ DATE SIGNED

FOR OFFICE USE ONLY:

ENROLLMENT		CUSTOMER CARE	MARKETING	NOTES
Group No.:		Received by:	Representative:	
Entered By:		Received date:		
Entered Date:		**UNDERWRITING**	Effective Date:	
Eff. Date:		Reviewed by:	Reviewed by:	
Member No.:		Received by:		

520 Route 8 Maite, Guam 96910