Change of Status
FORM

StayWell INSURANCE

LAST NAME	FIRST NAME	M.I.
ADDRESS CHANGE: ☐ (YES) MAILING ADDRESS		
MEMBER ID NO./ SSN	MARITAL STATUS	SEX / DOB
EMPLOYER	E-MAIL / CELL PHONE	WORK PHONE (INCL. EXT.)

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 NO.	DOB	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 request. Transferring of plans includes currend 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 agree and understand that StayWell will charge an additional service, collection or attorney fee for the collection of any amounts owed to StayWell for services rendered or products purchased on behalf of members covered by the Plan. I understand that approving coverage does not constitute acceptance of eligibility by StayWell Insurance until I provide all requested documents. I have discussed the terms of this authorization with all competent adults named in this form and I have obtained their consent to those terms.

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:		