

Change Form

Claims Administrator:
Consociate • Dansig
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9081-Eligibility changes

Active Employee _____ COBRA _____

Employee Information (please type or print)

Participants Name: _____
Last Name First Name

Social Security No: _____

Employer Name: _____

Reason For Change: (Select appropriate reason for change) Effective Date of Change: _____

- | | |
|-------------------|------------------------------|
| _____ Termination | _____ Date of Termination |
| _____ Divorce | _____ Date of Divorce |
| _____ Newborn | _____ Date of Birth |
| _____ Marriage | _____ Date of Marriage |
| _____ Other | _____ Reason/Date for Change |

Name Change:

From: _____ To: _____

Address Change:

From: _____ To: _____
Street Address Street Address

City, State, Zip City, State, Zip

Change of Benefits

Select the appropriate change of coverage

- | | |
|-------------------------|-------------------------|
| Change From: | Change To: |
| _____ Employee Only | _____ Employee & Family |
| _____ Employee & Family | _____ Employee Only |

ADD (+) or DELETE (-) Dependents (select one)

First Name	Last Name	Social Security #	Relationship	Date of Birth	+ -
		- -		/ /	<input type="checkbox"/> <input type="checkbox"/>
		- -		/ /	<input type="checkbox"/> <input type="checkbox"/>
		- -		/ /	<input type="checkbox"/> <input type="checkbox"/>
		- -		/ /	<input type="checkbox"/> <input type="checkbox"/>
		- -		/ /	<input type="checkbox"/> <input type="checkbox"/>
		- -		/ /	<input type="checkbox"/> <input type="checkbox"/>

Coordination of Benefits Information

Does spouse or dependents have other group health insurance coverage? Yes / No If Yes, complete the following information.

List those covered: _____

Company Name: _____ Insured's Name: _____

Address: _____ Insured's Date of Birth: _____

Policy Number: _____

Employee Signature

I hereby represent that my answers and statements as completed on this form are correct, to the best of my knowledge. I certify that each child named as covered under the Medical Benefits Plan is considered a "dependent" as defined in the Plan.

Signed by: _____ Date: _____

Employer Signature

I hereby represent that my answers and statements as completed on this form are correct, to the best of my knowledge. I certify that each child named as covered under the Medical Benefits Plan is considered a "dependent" as defined in the Plan.

Signed by: _____ Date: _____

