

Change Form

CLAIMS PROCESSED BY:
Consociate Dansig
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (800) 798-2422
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 _____

<input type="checkbox"/> Termination <input type="checkbox"/> Divorce <input type="checkbox"/> Newborn <input type="checkbox"/> Marriage <input type="checkbox"/> Other	<input type="checkbox"/> Date of Termination <input type="checkbox"/> Date of Divorce <input type="checkbox"/> Date of Birth <input type="checkbox"/> Date of Marriage <input type="checkbox"/> Reason/ Date for Change
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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: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Family	Change To: <input type="checkbox"/> Employee & Family <input type="checkbox"/> Employee Only
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ADD or DELETE Dependents (Circle One)

First Name	Last Name	Social Security #	Relationship	Date of Birth
		-- --		/ /
		-- --		/ /
		-- --		/ /
		-- --		/ /
		-- --		/ /
		-- --		/ /

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: _____

