HEALTH INFORMATION CHANGE FORM

(Please print all information)

Last Name	**First Name**	**Initial**	**Policy No.:**		
Name of Employer (If a group plan)			**Cert. No.** (If a group plan)		
SEX	**MARITAL STATUS**		**DATE OF BIRTH**		
			DD	MM	YYYY
☐ Male ☐ Female	☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Common Law ☐ Widow(er)				

OFFICE USE ONLY
☐ Declined: Date:
☐ Approved Date:
Effective date of Change:
Remarks:

FAMILY MEMBERS TO BE ADDED OR REMOVED				
FULL NAME	DATE OF BIRTH			RELATIONSHIP
	DD	MM	YYYY	

CHANGE DESIRED
(Please complete appropriate section below)

1. Change Coverage to: ☐ Silver ☐ Gold
2. Change Hospital Room Class to ☐ 1st ☐ 2nd ☐ 3rd
3. ☐ Add Family Member
4. ☐ Remove family Member Date: ____________________
5. ☐ Change of Address
6. ☐ Change of Agent/Broker
7. ☐ Change of Beneficiary
8. ☐ Change of Employee/Insured/Dependent's Name
9. ☐ Terminate the above Individual Policy
10. ☐ Reinstate the above Individual Policy

If adding a spouse, give date of marriage and provide copy of marriage certificate. (DD/MM/YYYY):	If child being added was adopted, give date of adoption and provide legal documentation: (DD/MM/YYYY):
If removing a family member, give reason: If adding dependent child please provide birth certificate:	Date Occurred: DD MM YYYY

CHANGE OF ADDRESS (please state new address here):

CHANGE OF AGENT/BROKER TO:

CHANGE OF BENEFICIARY

I hereby designate the below beneficiary (ies) under the certificate and revoke the appointment of any existing beneficiary. I reserve the right, without consent of the beneficiary, to further change the beneficiary subject to any statutory restrictions.

Last Name	First Name	Relationship to Employee

BENEFICIARY WITNESS - (Required if beneficiaries are listed)

1. Name:	Signature:
2. Name:	Signature:

CHANGE OF ☐EMPLOYEE ☐PRIMARY INSURED OR ☐DEPENDENT NAME TO:

Last Name	First Name	Middle Name

Reason: ☐ Marriage (attach copy of marriage certificate) ☐ Other (specify and attach supporting documents)

______________________ Signature of Insured

______________________ Signature of Employer

______________________ Date