

Small Employer Company Name and/or Ownership Change Form

Date: _____

Current Name of Company: _____ SelectHealth Group #: G _____

Please indicate the effective date for the following changes: _____
MM/DD/YY

Is there a new company name? Yes No If yes, indicate new company name below:

What is the reason for the name change? _____

Please list your current tax ID number: _____

Is there a new tax ID number? Yes No If yes, indicate new tax ID number: _____

If the tax ID number changed, what date did the tax ID number officially change? _____
MM/DD/YY

Is there a new address? Yes No If yes, indicate new address: _____

Is there a new phone number? Yes No If yes, indicate new phone number: _____

Is there a new contact person(s) for the group? Yes No If yes, please list name of new contact person(s):

Billing contact name: _____ Business contact name: _____

Is the nature of the business changing? Yes No If yes, please describe the nature of the business.

Is there a change of ownership? Yes No If yes, list the name of the new owner(s):

If there is a change in the ownership, is the prior owner currently a co-owner of the company with the new owner(s)? Yes No

If yes, who is the majority share owner? _____

Will the prior owner remain with the group? Yes No

If yes, is the prior owner working a consistent 30 hours every week? Yes No

Are there any changes in employee status? Adding or Removing employees due to the name/ownership change? Please indicate below:

EMPLOYEE NAME	ADDING	REMOVING	EFFECTIVE DATE
_____	<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"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are any employees waiving coverage due to other group coverage through a spouse or parent? Yes No

If yes, please list the name(s) of those employees: _____

Signature of Company Official who completed this form: _____

Printed Name of Company Official that signed above: _____

Title of Company Official: _____ Date of signature: _____

MM/DD/YY