

NationCare Change Form Small Employer

Complete Applicable Sections Only

Employee Name _____ Subscriber ID _____ Date of Birth _____

A. EMPLOYEE INFORMATION CHANGE

Name Changed From _____ Marital Status Change Legally Married Divorced Death

Name Changed To _____ Effective Date of Marital Change _____

New Address _____

City _____ State _____ ZIP _____ New Ph# _____

B. ADD NEWBORN/ADOPTED CHILD ONLY

Use this section only to add newborn children, adopted children, or children placed for adoption. This Change Form must be submitted within **31 days** from the child's date of birth, adoption, or placement for adoption. All other dependents must submit a completed Employee Application.

Last Name	First Name	Initial	Sex	Relationship	Date of Birth (MM/DD/YY)
1.			M/F	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted*	
2.			M/F	<input type="checkbox"/> Natural <input type="checkbox"/> Adopted*	

*Submit copy of adoption or placement papers

C. DELETE FAMILY MEMBERS

Delete Children

Last Name	First Name	Initial	Effective Date (MM/DD/YY)	Reason
1.				
2.				
3.				

Delete Spouse

Last Name	First Name	Initial	Effective Date (MM/DD/YY)	Reason
				<input type="checkbox"/> Death <input type="checkbox"/> Annulment* <input type="checkbox"/> Divorce* <input type="checkbox"/> Other <input type="checkbox"/> Open Enrollment

*If you are deleting coverage for your spouse as a result of a recent divorce or annulment, please complete the following:

- If you have family coverage**, you must submit the first and last page of the divorce decree and any page specifying coverage responsibilities for dependent children.
- If you do not have family coverage**, your spouse may sign this form below acknowledging the request to discontinue coverage, or you may submit a copy of the first and last page of the divorce decree.

By signing this form, I acknowledge that I will no longer have healthcare coverage through NationCare. I understand that I may have rights to continue coverage as the result of my recent divorce and that additional information regarding how to continue coverage may be obtained through the Plan sponsor (spouse's employer).

Spouse's Signature _____ Date _____

Except for the reason of death or at open enrollment, spouse's signature is required.

D. EMPLOYEE TERMINATION/DISCONTINUATION OF MEDICAL BENEFITS (Check any applicable boxes for employee only)

Actual Date of Change _____ (Last day worked/lost eligibility/retired, etc.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Termination of employment | <input type="checkbox"/> Leaving for active military service | <input type="checkbox"/> No longer want coverage |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Loss of eligibility (full- to part-time, etc. but still employed) | <input type="checkbox"/> Waiving medical coverage (due to group coverage under a spouse or parent plan). <i>Must submit a Waiver Form</i> |
| <input type="checkbox"/> Death (employee signature not required) | <input type="checkbox"/> Termination of COBRA coverage | |

E. EMPLOYEE SIGNATURE

By signing, you agree to the changes requested above.

Employee's Signature _____ Date _____

F. EMPLOYER INFORMATION (Must be completed)

Note: If an employee is applying for COBRA coverage, proof of COBRA eligibility may be required. Employees applying for COBRA coverage must complete a separate COBRA Form. COBRA questions can be answered by calling 415-625-2481. COBRA forms can be obtained by calling 801-442-5615.

After completing this Change Form, return by faxing to 801-442-5798.

Employer's Signature _____ Date _____

Company Name _____ Group# _____

Comments _____