



APPLICATION FOR EMPLOYEE CHANGE

GETTYSBURG HEALTH ADMINISTRATORS
 404 BALTIMORE STREET / P.O. BOX 1060
 GETTYSBURG, PA 17325-1060

Boxes 1 thru 8 MUST be completed. Please press firmly and use a ball point pen.		Please read instructions on back.
1) EMPLOYEE'S LAST NAME, FIRST NAME, M.I.		2) SOCIAL SECURITY # / AGREEMENT #
3) EMPLOYEE'S ADDRESS		
4) COMPANY / GROUP NAME		5) GETTYSBURG HEALTH ADMINISTRATORS GROUP ID# FOR ALL COVERAGES)
6) Please make the following changes to my Agreement effective (month & day) IMPORTANT: If the employee has terminated employment, this date must be their last day of employment. _____ 20_____		
7) Please make the following changes effective to the following coverages: <input type="checkbox"/> Health <input type="checkbox"/> Life/Disability <input type="checkbox"/> Delta Dental <input type="checkbox"/> Dental <input type="checkbox"/> Prescription Plan <input type="checkbox"/> Vision <input type="checkbox"/> Long Term Disability		
8) EMPLOYEE SIGNATURE (If employee is not available for signature, the corresponding person needs to write: "Not available for signature." The correspondent then signs his/ her own signature.) X _____ DATE: ____/____/____		

A. NAME CHANGE - From: _____ To: _____

B. CHANGE OF HOME ADDRESS TO: _____ City _____ State _____ Zip _____

C. CHANGE PHONE # to: () - _____

D. ADD DEPENDENTS - Enroll the dependents listed below. (NOTE: Completion of a Health Statement, Evidence of Insurability, is required.)

First Name, MI (Last Name, if different from Employee's)	Relation	Birthdate	Sex	Social Security #	Medicare or RR Retiree ID #	Fulltime Student *

* Attach completed Student Verification Form for each unmarried child, age 19 or over, who is fulltime student in an accredited school.
REASON FOR ADDITION (For spouse, include date of marriage. For adopted child, include a copy of adoption papers.)

OTHER COVERAGE INFORMATION (Complete when adding dependents to your Agreement.)

Place a check next to all who are now covered by other Group Health Insurance.

Myself My Spouse My dependent children None

Name of Insurance Carrier	Name of Group	Coverage Issued To: <input type="checkbox"/> Me <input type="checkbox"/> My spouse <input type="checkbox"/> Other	Effective Date / /	Spouse's Birthdate / /

E. CANCEL EMPLOYEE COVERAGE. Give Reason for Cancellation:

F. CANCEL BENEFITS FOR THE ENROLLED DEPENDENTS LISTED BELOW.

First Name, MI (Last Name, if different)	Relation	Birthdate	Sex	Reason for Cancellation

G. COBRA ELECTION-Effective Date: ____/____/____ **Termination Date:** ____/____/____ **NOTE: THIS IS TO ENROLL IN COBRA ONLY!**
 1. EE only EE and Dependents Dependents Only 2. Core Coverage only Core coverage & Non-Core Coverage

H. OTHER CHANGE:

For Office Use Only	RETURN ALL COPIES OF THIS FORM INTACT.
Approved: _____	By: _____ Effective Date of Change: _____ Notes: _____ s/doc/ghai/apforechange (9/13/01)

IF YOU ARE APPLYING FOR INSURANCE FOR PERSONS NOT CURRENTLY ENROLLED AS DEPENDENTS:

Your signature on the front of this form (# 8) affirms that you understand the insurance will be effective only upon approval of this application. The agreement will be binding only if the statements you make to induce acceptance of this application are true and complete to the best of your knowledge.

A Health Statement (Evidence of Insurability) must be completed and submitted with this form for any dependents being added to the coverage.

IF YOU NEED ADDITIONAL SPACE, PLEASE ATTACH AN EXTRA FORM.

RETURN ALL COPIES OF THIS FORM INTACT.