

Application for Employee Change
Administered By: Gettysburg Health Administrators, Inc.
 34 Locust Ave., P.O. Box 1060 Gettysburg, PA 17325-1060
 Fax: 717-334-5851

Please complete each section of this application in ink.

Shaded Area For Office Use Only	Group #:	Eff. Date:	Processed by:	Date:
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Applicant Information (Employee)

Name of Employer:	GettHealth Group ID#:
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Employee Name (last, first, initial)	Social Security Number: - -
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Please make the following changes to my Agreement effective: _____/_____/_____	Please make the following changes to the following coverages: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life/Disability <input type="checkbox"/> Long Term Disability
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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: ____/____/____

Information Requiring Change/Addition

Name Change: From: _____ To: _____
Home Address (Street or Route) City, State, Zip Code:

Change of Address to:

Change of Phone Number to:

Reinstate Date (return from layoff date):

Add Dependent – This form can only be used to add newborn children within 30 days of birth.

Family Member's Name (last, first, initial)	Status	Gender	Date of Birth (mm/dd/yy)	Social Security #	Height (ft – in)	Weight (lbs)	Enroll in Medical	Enroll in Dental	Enroll in Vision
Family Member's Name (last, first, initial)	CHILD	<input type="checkbox"/> M <input type="checkbox"/> F	/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

To Cancel Coverage

Cancel Employee Coverage: (Give reason for cancelling coverage)

Cancel Coverage for the Enrolled Dependents Listed Below (Give reason for cancelling coverage):

Family Member's Name (last, first, initial)	Status	Gender	Date of Birth (mm/dd/yy)	Reason for Cancellation:
Family Member's Name (last, first, initial)	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	
Family Member's Name (last, first, initial)	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	
Family Member's Name (last, first, initial)	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	
Family Member's Name (last, first, initial)	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	

Cobra Election (Note: This is to enroll in COBRA only): Employer over 20 lives Employer less than 20 lives

Effective Date: ____/____/____ Termination Date: ____/____/____

Please Enroll: Employee Only Employee and Dependents Dependents Only Core Coverage Only Core coverage & Non-Core Coverage

Dependent to be enrolled info: _____
Name (last, first, initial) Social Security #

Other Change:

Medicare Supplement Election (only applies to Group under 20 ; send along copy of Medicare card): Medical Only Medical with Rx

Please list other change: _____