



EXISTING MEMBER TERMINATION / CHANGE FORM

Please print clearly in CAPITAL letters Please fill in the circles completely ●

1 GENERAL INFORMATION

Company Name		KELLY Company ID#	
Last Name	First Name	MI	Title (Jr., III, etc.)
Social Security#	Date of Birth (MM-DD-YY)	Employer Phone#	

2 EMPLOYEE TERMINATION OF COVERAGE

Terminate **ALL** Active Lines of Coverage
 Health
 Vision
 Vol. Life
 Vol. Sp. Life
 STD
 LTD
 Suppl. Life/AD&D
 Dental
 Life/AD&D
 Vol. AD&D
 Vol. Dep. Life
 Vol. STD
 Vol. LTD

Reason for Termination:
 Death of Employee
 Loss of Dependent Status
 Non-Payment of COBRA Premium
 Employment Status Change
 Enrollment in Medicare
 Dropping Coverage Voluntarily
 Gain of Other Coverage
 End of Employment
 Reduction in Hours
 Court Ordered Cancellation
 Not Eligible
 Other: _____

Important: Involuntary Termination? Yes / No
 Eligible for COBRA/Continuation subsidy under ARRA? Yes / No

Qualifying Event Date: _____ / _____ / _____
Coverage Term Date: _____ / _____ / _____

3 CHANGE IN CURRENT COVERAGE LEVEL

MEDICAL ONLY		DENTAL ONLY		VISION ONLY		ALL LINES		OTHER Plan _____	
FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
<input type="radio"/> Employee Only	<input type="radio"/>	<input type="radio"/> Employee Only	<input type="radio"/>	<input type="radio"/> Employee Only	<input type="radio"/>	<input type="radio"/> Employee Only	<input type="radio"/>	<input type="radio"/> Employee Only	<input type="radio"/>
<input type="radio"/> Employee & 1 Child	<input type="radio"/>	<input type="radio"/> Employee & 1 Child	<input type="radio"/>	<input type="radio"/> Employee & 1 Child	<input type="radio"/>	<input type="radio"/> Employee & 1 Child	<input type="radio"/>	<input type="radio"/> Employee & 1 Child	<input type="radio"/>
<input type="radio"/> Employee & Spouse	<input type="radio"/>	<input type="radio"/> Employee & Spouse	<input type="radio"/>	<input type="radio"/> Employee & Spouse	<input type="radio"/>	<input type="radio"/> Employee & Spouse	<input type="radio"/>	<input type="radio"/> Employee & Spouse	<input type="radio"/>
<input type="radio"/> Family	<input type="radio"/>	<input type="radio"/> Family	<input type="radio"/>	<input type="radio"/> Family	<input type="radio"/>	<input type="radio"/> Family	<input type="radio"/>	<input type="radio"/> Family	<input type="radio"/>

Qualifying Event:
 Marriage
 Newborn / Adoption
 Loss of Coverage
Qualifying Event Date: _____ / _____ / _____
Requested Date of Change: _____ / _____ / _____

Last, Full First, M.I.	Social Security #	Birth Date	Sex (M/F)	F/T Student (Y/N)*	Disabled (Y/N)	POS or HMO only:		Existing Patient (Y/N)
						Line 1: PCP Info: Physician Name	Line 2: OB/GYN Info: Physician #	
Sp								
Chd								
Chd								
Chd								

*If full time student, please submit proper form, or appropriate verification of student status (e.g. class schedule, statement from Registrar's office, cancelled check)

Are you or any of your dependents eligible for Medicare? If Yes: Effective Date (Part A) _____ / _____ / _____ Effective Date (Part B) _____ / _____ / _____

4 MISCELLANEOUS CHANGES

Name Change: From: _____ To: _____
Address Change: From: _____ To: _____
Telephone Number Change: From: (____) _____ To: (____) _____
Salary Change: From: \$ _____ To: \$ _____ Effective Date of Change: _____ / _____ / _____
Provider Change: PCP OB/GYN DENTIST Change for all members?: Y N If no, list member name: _____
 From: _____ # _____ To: _____ # _____ Existing Patient: Y N
Medicare: Add Drop
 Name: _____ Medicare ID #: _____ Part A: _____ / _____ / _____ Part B: _____ / _____ / _____
Beneficiary Change- Life Insurance: I am changing my group term Life Insurance beneficiary(s) (Please print full name including middle initial)
 Primary To: _____ Relationship: _____
 Secondary To: _____ Relationship: _____

5 EMPLOYEE SIGNATURE

DATE _____ / _____ / _____

Note: Form invalid without required signatures

EMPLOYER SIGNATURE / VERIFICATION _____

DATE _____ / _____ / _____