SIHO INSURANCE SERVICES

CHANGE REQUEST FORM

Please either mail this form to SIHO, 417 Washington Street, Columbus, IN 47201 attn: Membership, fax it to 812-373-8717 or email to membership.dept@siho.org.

Employer _____ Group No. _____

Employee _____ ID # _____ Phone (_____)_____

For these sections, please also complete reverse side

Add Spouse

Name _____ Hgt/Wgt _____ Date of Birth _____

Please check which coverage(s) to add: ☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life

Reason to add _____ Spouse employed: ☐ Yes ☐ No Spouse's S.S. #_____

What is the Qualifying Event: _____Date of Qualifying Event_____

If enrollment is due to a qualifying event, proof of qualifying event (divorce decree, Certificate of Creditable Coverage, Medicaid or other) must accompany this form.

Employer Name/Address_____

Spouse insured elsewhere? ☐ **Yes** ☐ **No** If yes, Insured by _____ Policy #:

Add Children

Full Name	Sex M / F	Birthday M/D/Y	S.S. Number	Full Time Student (Y/N)	Reason to Add	Date of Qualifying Event

Please check which coverage(s) to add: ☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life

Children insured elsewhere? ☐ **Yes** ☐ **No** If yes, Insurance Co.: _____ Policy #: _____

Are any of the other Dependents listed above in the legal custody of another person? ☐ **Yes** ☐ **No** If yes:

If enrollment is due to a qualifying event, proof of qualifying event (divorce decree, Certificate of Creditable Coverage, Medicaid or other) must accompany this form.

Dependent	Person with Legal Custody	Relationship to Dependent	Address of Custodian

Termination And Changes

☐ Employee Termination, indicate last day of work _____ ☐ Voluntary ☐ Involuntary

(Benefits will end on last day of month following termination.)

☐ Employee Request for Termination of Benefits (benefits will end on last day of month):

☐ Delete employee coverage, effective date _____ Reason: _____

Please check which coverage(s) to delete: ☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life

☐ Delete spouse's coverage, effective date _____ Reason: _____

Please check which coverage(s) to delete: ☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life

☐ Delete children's coverage, effective date _____ Reason: _____

Please check which coverage(s) to delete: ☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life

Change Name: ☐ Employee Name ☐ Dependent's Name _____

Reason: ☐ Marriage ☐ Divorce ☐ Other, describe _____

Change Name to _____

Change address:_____

New Address: _____

Change Life Insurance Beneficiary:

Primary - Full Name:_____ Relationship_____ %_____

Secondary - Full Name:_____Relationship_____ %_____

Explanation of Benefits (EOB) preference (Please choose one): ☐ Email Notification or ☐ Print

Apply to all under 18 dependents ☐ Yes ☐ No

I authorized SIHO to make the above changes to my current benefits.

Note: No employee signature is necessary if employment is terminated. All other changes must be authorized by the employee.

Employee signature: _____ Date: _____ Employer signature: _____

WARNING: any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits and application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.

MEDICAL MANAGEMENT*

Medical Conditions (please check Yes or No)

1. Has any person added been advised that **hospitalization or surgery** is needed or anticipated? ☐ **Yes** ☐ **No**

2. Has any person added in the **past two (2) years** been diagnosed, received treatment, or had medication prescribed for, but not limited to, the following conditions: Cancer; Stroke; Diabetes; Heart or Vascular Disease; Mental or Emotional Disorder; Muscular or Systemic Disease (Arthritis / Lupus); Alcohol / Drug Abuse; Liver; Kidney; Lung or Intestinal Disorder; AIDS / HIV? ☐ **Yes** ☐ **No**

Covered Member (Full Name)	Illnesses or Conditions	Date of Diagnosis, Medication, Treatment or Prognosis	Treating Physician's Name

*Information used solely by SIHO Medical Management to ensure quality and coordination of care for members.

To the best of my knowledge, all of the above information is believed by me to be true.

_____ _____

Signature of Employee **Date**

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417 Washington Street
Columbus, IN 47201
800-443-2980
www.siho.org