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.

## Changes

Employer_____________________________________________ Group No. _______________________________________

Employee ____________________ ID # ______________Phone (______)____________ Email:_________________________

**Change Deductible Plan:** Current__________________ to New_____________________ (Open Enrollment Only)

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

Reason: ☐ Marriage ☐ Divorce ☐ Other, describe ________________________________

Change Name to _______________________________________________________________________________________

Change Life Insurance Beneficiary: ☐ Life ☐ Dependent Life (Dependent Life Beneficiary is Employee)

Primary - Full Name:___________________________________ Relationship___________________________ %__________

Secondary - Full Name:_________________________________ Relationship___________________________ %__________

New Address (if applicable): ___________________________________________________________________________

## Add Spouse

Name ____________________________________ Date of Birth ____________________

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

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 | Reason to Add | Date of Qualifying Event |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

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

Children insured elsewhere? o **Yes** o **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

☐ Termination of Employment, 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 ☐ Life

If applicable, is Employee Life only? ☐ Yes ☐ No

☐ Delete spouse's coverage, effective date _______________ Reason: ______________________

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

☐ Delete children's coverage, effective date _______________ Reason: ______________________

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

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.