Aegis Security Insurance Company **CHANGE**
PART-TIMERS/INDEPENDENT CONTRACTORS GROUP BENEFITS PROGRAM **FORM**

Read the back of this Form for important information on when you may make changes. When you have completed this Form, make a copy for yourself. Give the completed original to your manager with any required documentation attached.

A. INFORMATION ABOUT YOU (Provide address information only if it has changed.)

SOCIAL SECURITY NUMBER **FIRST NAME** **MIDDLE INITIAL** **LAST NAME**
___ - ___ - ____

MAILING ADDRESS **CITY** **STATE** **ZIP CODE**

HOME PHONE **BIRTHDATE** **SEX**
(_____) _____ _____/_____/_____ **__ M __F**
MM DD YY

B. REQUESTED CHANGE: **(Check all that apply.)** **EFFECTIVE DATE OF CHANGE: _____/_____/_____**

___ Add coverage for yourself ___ Add coverage for a dependent

- If you checked either of these boxes, please read the back of this Form about *Special Enrollments* before completing this Form.
- If this coverage you are adding is the result of an ___ LOC or an ___ FSC, enter the number and date.
  LOC/FSC Number: _____ Date of LOC/FSC: _____ Attach supporting documentation.

___ Drop a dependent ___ Drop indicated coverage for yourself ___ Drop all coverage for yourself
___ Change information only ___ Change your Beneficiary

I authorize my employer to change my benefit elections as noted below and to deduct from my pay the required contribution.

PRINT NAME _____ YOUR SIGNATURE _____ DATE _____/_____/_____
MM DD YY

C. YOUR BENEFIT CHOICES **(Check the box that indicates the coverage action you want)**

___ *Add* ___ Yourself Only
___ *Drop* ___ Yourself & One Dependent
___ *Change to* ___ Yourself & Family

D. YOUR DEPENDENTS INFORMATION **Check here ___ if you have more dependents to add/drop and provide all requested information on an attached separate sheet.**

1. Dependent to ___*Add* or ___*Drop* Check here ___ if living at a different address and list on the back. **RELATIONSHIP** **SEX** **BIRTH DATE**
FIRST NAME INITIAL LAST NAME __ Your Spouse ___M ____/_____/____
MM DD YY
_____ __ Your Child ___F

IF OVER 18, IS YOUR CHILD: ___ FULL TIME STUDENT? ___ DISABLED? **YOUR DEPENDENT'S SSN:_____-_____-_____**

2. Dependent to ___*Add* or ___*Drop* Check here ___ if living at a different address and list on the back. **RELATIONSHIP** **SEX** **BIRTH DATE**
FIRST NAME INITIAL LAST NAME __ Your Spouse ___M ____/_____/____
MM DD YY
_____ __ Your Child ___F

IF OVER 18, IS YOUR CHILD: ___ FULL TIME STUDENT? ___ DISABLED? **YOUR DEPENDENT'S SSN:_____-_____-_____**

3. Dependent to ___*Add* or ___*Drop* Check here ___ if living at a different address and list on the back. **RELATIONSHIP** **SEX** **BIRTH DATE**
FIRST NAME INITIAL LAST NAME __ Your Spouse ___M ____/_____/____
MM DD YY
_____ __ Your Child ___F

IF OVER 18, IS YOUR CHILD: ___ FULL TIME STUDENT? ___ DISABLED? **YOUR DEPENDENT'S SSN:_____-_____-_____**

E. WHO IS YOUR BENEFICIARY?
FIRST NAME INITIAL LAST NAME
_____

WHAT IS YOUR BENEFICIARY'S RELATIONSHIP TO YOU: ___ Spouse ___ Child ___Brother/Sister ___ Parent ___ Other (specify)_____

FOR POLICYHOLDER'S USE ONLY

INSURED ID:	CONTRACT DATE: _____/_____/_____ MM DD YY	PAY TYPE: DEDUCTION $_____
LOCATION OR SITE CODE:	AUTHORIZED SIGNATURE:	DATE: _____/_____/_____ MM DD YY

HOW TO USE THIS CHANGE FORM

This form allows you to: **1. enroll** yourself and your dependents in the Plan between Open Enrollment Periods, or **2. change** enrollments including dropping coverage (your employer's Plan may have certain requirements that affect your ability to drop coverage). You may also use this form to change information about yourself, your dependents or your beneficiary (see number 2, below). Please read each carefully until you find the one that applies to what you are trying to do.

1. Enrollment Between Open Enrollment Periods: Special Enrollment

EVENTS RESULTING IN A LOSS OF OTHER COVERAGE
1. Divorce, legal separation or death
2. Termination of employment of a dependent
3. Reduction of a dependent's hours
4. Termination of your or your dependent's COBRA rights
5. Loss of employer's contribution to spouse's coverage
6. Other loss of coverage

A. Loss of Other Coverage (LOC): If you previously declined health coverage because you or your dependents were already covered under another health plan and you or your dependents have lost that other coverage, you may be allowed to enroll yourself and your dependents. You must submit this form, together with documentation, to your employer within 31 days of the LOC. If you are entitled to this special enrollment, complete **Section A,** on the front, then go to **Section B,** check the LOC box, supply the LOC Number and date, and finish completing this form through **Section E.** When finished, make a copy of this form and give it to your supervisor with your documentation attached.

QUALIFYING FAMILY STATUS CHANGE EVENTS
7. Marriage
8. Birth or adoption of a dependent
9. Other

B. Family Status Change (FSC): Whether you are currently enrolled or previously declined coverage, you may be allowed to add or change enrollment when you experience certain FSC events. You must submit this form, together with documentation, to your supervisor within 31 days of the FSC. If you are entitled to add or change enrollment because of a recent FSC, complete **Section A,** on the front, then go to **Section B,** check the FSC box, supply the FSC Number and date, and finish completing this form through **Section E.** When finished, make a copy of this form and give it to your supervisor with your documentation attached.

ADDRESSES OF DEPENDENTS NOT LIVING WITH YOU

DEPENDENT'S NAME(S):

_____

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

_____

DEPENDENT'S NAME(S):

_____

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

_____

If you have additional dependents and addresses, please record all requested information on a separate sheet and attach it to this form.