

KELLY & ASSOCIATES INSURANCE GROUP, INC. 301 International Circle · Hunt Valley, Maryland 21030-1342 · (410) 527-3432 · Fax: (410) 527-5905 · www.kaig.com

EXISTING MEMBER TERMINATION / CHANGE FORM

Please print clearly in CAPITAL letters

EMPLOYER SIGNATURE / VERIFICATION

Please fill in the circles completely

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signatures

Company Name	1	GENERAL INFORMATION											
Social Security# Date of Birth AMADD YN Employeer Phone#		Company Name	pany Name KELLY Company ID#										
EMPLOYEE TERMINATION OF COVERAGE Terminate ALL Active		Last Name			First Name				M	Title (Jr., III, etc	.)		
EMPLOYEE TERMINATION OF COVERAGE Terminate ALL Active		Social Security#	Date of	Birth (MM-DD-YY)		Emplo	over Phone#						
Terminate ALL Active Dental Vision Vol. Life Vol. Sp. Life STD LTD Suppl. Life(AD&D Vol. Lines of Coverage Dental Cultification Vol. AD&D Vol. Dep. Life STD Vol. STD Vol. LTD Suppl. Life(AD&D Vol. Eng. Life Vol. STD Vol. LTD Suppl. Life(AD&D Vol. Eng. Life Vol. STD Vol. LTD Vol. LTD Suppl. Life(AD&D Vol. Eng. Life Vol. STD Vol. Eng. Life Vol. Eng. Life Vol. Eng. Life Vol. Std Vol. Eng. Life Vol. Eng. Life Vol. Std Vol. Eng. Life Vol. Std Vol. Eng. Life Vo		,											
Lines of Coverage	2	EMPLOYEE TERMINATION OF COV	ERAGE										
Reason for Termination: Death of Employee Closs of Dependent Status Non-Payment of COBRA Premium Event Date: Coverage Country Coun		Terminate ALL Active Health Vision Vol. Life Vol. Sp. Life STD LTD Suppl. Life/AD&D											
Event Date: Court Ordered Cancellation Not Eligible Other: Coverage		, ,			<u> </u>			RA Premium	Qualifyin				
CHANGE IN CURRENT COVERAGE LEVEL MEDICAL ONLY FROM Employee Chily Employee Chily Employee Chily Employee Child Employee Child Employee & 1		○ Employment Status Change ○ Enrollme	ent in Medicare O Droppi	ing Coverage V	oluntarily 🔾	Gain of	Other Coverag	e 	Coverage				
MEDICAL ONLY FROM Employee Cniy Employee Cniy Employee & Spouse Employee & Spouse Family Gualifying Event: Marriage Newborn / Adoption Loss of Coverage Newborn / Adoption Loss of Coverage Event Date: Marriage Newborn / Adoption Loss of Loss of Coverage Event Date: Last, Full First, M.I. Social Security # Birth Date Mif 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) MISCELLANEOUS CHANGES Name Change: From: To: Telephone Number Change: From: To: Salary Change: Prom: \$ To: \$ Effective Date of Change: // To: \$ Effective Date of Change: // If no, list member name:	2												
Employee Only FROM Employee Only Employee Only Employee Only Employee & 1 Child E	9			VISI	ON ONLY		ALL	LINES	ОТНЕ	R Plan			
Employee & 1 Child Employee & 1 Child Employee & 1 Child Employee & 1 Child Employee & 5 Spouse Sp		FROM TO FROM	TO-1	FROM		ТО	FROM	ТО					
Employee & Spouse Employee & Spouse Family Employee & Spouse Family Employee & Spouse Family Family Family Requested Date Family Family Family Family Gualifying Family Family Family Family Family Family Family Requested Date Family Fa			· · · · —	· — ·	•	Н	—		Щ				
Family			· · · —	I 		Н	⊢ · · ·						
Event: Marriage Newborn / Adoption Coss of Coverage Event Date: / of Change: /			· · · · · · · · · · · · · · · · · · ·	· 🛏 · · ·		\Box	—	· <u>–</u>					
Last, Full First, M.I. Social Security # Birth Date Sex M(MF) Student Disabled Line 1: PCP Info; Line 2: OB/GYN Info Physician # Physician # Physician # Physician # Physician # Physician # Physician Name Physician # Physician * Physician * Physician * Physician * Physician * Physici		Qualifying Marriage Newborn	Adoption O Loss of Co	overage						1	/		
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) / MISCELLANEOUS CHANGES Name Change: From:								POS oi	r HMO oi				
Chd Chd Tif 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) / MISCELLANEOUS CHANGES Name Change: From: To: Address Change: From: To: Telephone Number Change: From: To: Telephone Number Change: From: To: Frowider Change: OPCP OB/GYN OBENTIST Change for all members?: OY ON If no, list member name:		Last, Full First, M.I.	Social Security #	Birth Dat			() (/) ()				_		
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) / MISCELLANEOUS CHANGES Name Change: From: To: To:		Sp				\ggg							
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Are you or any of your dependents eligible for Medicare? If Yes: Effective Date (Part A) /		Chd											
MISCELLANEOUS CHANGES Name Change: From:		·				. class s			ffice, canc	elled check)			
Name Change : From: To: Address Change: From: To: Telephone Number Change: From: () To: () Salary Change: From: \$ To: \$ Effective Date of Change: / / Provider Change: OPCP OB/GYN ODENTIST Change for all members?: OY N If no, list member name:	4		for Medicare? If Yes: Effec	ctive Date (Part A))	<u>/</u>	_/ Effe	ective Date (Part B) _	/	/			
Address Change: From:					7	·o:							
Telephone Number Change: From: () To: () Salary Change: From: \$ To: \$ Effective Date of Change: / / Provider Change: OPCP OB/GYN ODENTIST Change for all members?: OY ON If no, list member name:													
Salary Change: From: \$ To: \$ Effective Date of Change:/													
Provider Change: OPCP OB/GYN ODENTIST Change for all members?: OY ON If no, list member name:													
Medicare: O Add O Drop													
Name:													
Beneficiary Change- Life Insurance: I am changing my group term Life Insurance beneficiary(s) (Please print full name including middle initial)													
1 Primary 10.													
Primary To: Relationship: Relationship:									Note:	Form invalid	1.26.11		
											1.26.11		
Secondary To: Relationship: Note: Form invalid 1.26.11		EWIFLOTEE SIGNATURE					DATE	<i>i I</i>	witho	out required			