KELLY & ASSOCIATES INSURANCE GROUP, INC.

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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 ______

Qualifying Event Date: ______

Coverage Term Date: ______

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

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
○	Employee Only	○	○	Employee Only	○	○	Employee Only	○	○	Employee Only	○	○	Employee Only	○
○	Employee & 1 Child	○	○	Employee & 1 Child	○	○	Employee & 1 Child	○	○	Employee & 1 Child	○	○	Employee & 1 Child	○
○	Employee & Spouse	○	○	Employee & Spouse	○	○	Employee & Spouse	○	○	Employee & Spouse	○	○	Employee & Spouse	○
○	Family	○	○	Family	○	○	Family	○	○	Family	○	○	Family	○

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:*** Line 1: PCP Info; Line 2: OB/GYN Info — Physician Name	Physician #	Existing Patient (Y/N)
Sp									
Chd									
Chd									
Chd									

*If full time student, please submit proper form, (... trar's office, cancelle(... eck)

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** ___/___/___

EMPLOYER SIGNATURE / VERIFICATION ______ **DATE** ___/___/___

Note: Form invalid without required signatures

3.8.09