

CHANGE FORM

Use this form to indicate changes to your member information, add or delete dependents, or cancel your coverage.

A. EMPLOYEE INFORMATION (AS IT APPEARS ON I.D. CARD)

First Name	M.I.	Last Name	Birthdate	Member I.D. Number (Required)
			/ /	- 0 0

B. EMPLOYEE CHANGES

1. Change Address to: _____

2. Change Name from: _____ to: _____

C. CHANGE IN COVERAGE

1. **Additions:** (check all that apply) Add Medical Coverage Add Dental Coverage

Qualifying Event (check one): Birth Adoption Marriage Other (specify): _____

2. **Deletions:** (check one) Cancel medical coverage only Cancel dental coverage only Delete dependents listed below

Cancel Life/AD&D Cancel Dep. Life only* Cancel S.T. Disability only Cancel all coverage

*MAY BE WAIVED ONLY ON SPOUSE WHO IS ALSO COVERED AS AN EMPLOYEE THROUGH THIS EMPLOYER

Reason (check one): Employee terminated Employee now ineligible Other: _____

Death Moved outside service area Dissatisfied Dependent now ineligible

3. **Changes:** Change to COBRA coverage Reason: _____

List all family members to be added, changed or deleted. Student status information is required for all student age dependents prior to enrollment. Do all dependents to be added live at the same address as the employee? YES NO If no, provide dependent address below.

Change	First Name	M.I.	Last Name	Relationship	Sex	Birthdate	Full-Time College Student	Social Security Number
Add					M	/ /	X	
Delete					F	/ /		
Change	Address (if different):							
Add					M	/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Delete					F	/ /	School Name & Location:	
Change	Address (if different):							
Add					M	/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Delete					F	/ /	School Name & Location:	
Change	Address (if different):							

D. OTHER INSURANCE INFORMATION (THIS SECTION MUST BE COMPLETED)

On the day your coverage begins will any family members, including those not listed above, be covered by other health or dental insurance or Medicare? Use extra paper if more than one additional policy will be in force. YES NO If yes, fill out this section.

Coverage type: <input type="checkbox"/> Medical Insurance <input type="checkbox"/> Dental Insurance <input type="checkbox"/> Medicare (see below)	Insurance Company Name and Phone Number	Policy Number
Policy Coverage Dates: _____ to _____	Name of Policyholder	Policyholder's Birthdate
Family Members Covered		Phone Number
Names of family members covered by Medicare	Medicare Claim Number	Part A Effective Date
Part B Effective Date	Is Medicare eligibility due to: <input type="checkbox"/> Kidney failure <input type="checkbox"/> Disability	

E. SIGNATURE (THIS FORM MUST BE SIGNED)

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give IBA Health and Life Assurance Company, or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my and/or my dependents' coverage.

NOTICE OF ENROLLMENT RIGHTS: I understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

X

Employee Signature _____ Date Signed _____

F. FOR EMPLOYER USE ONLY

Company Name	Branch/Division	Group Number
Effective Date of Change	Approved by	Employer's Phone No.
		Date

FOR INSURANCE COMPANY USE ONLY

Effective Date(s)	County	Rate Class
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ENROLLMENT FORM

IBA Health and Life Assurance Company

A. EMPLOYEE INFORMATION

First Name	M.I.	Last Name	Your Beneficiary's Full Name	Relationship
Street Address		Apt. No.	City	State
				Zip Code
				County
Home Phone () ()	Work Phone () ()	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	Application for (check all that apply):	
Social Security Number	Sex M F	Birthdate / /	<input type="checkbox"/> Single Medical Coverage <input type="checkbox"/> Family Medical Coverage <input type="checkbox"/> Single Dental Coverage <input type="checkbox"/> Family Dental Coverage	<input type="checkbox"/> Life/AD&D <input type="checkbox"/> Dependent Life <input type="checkbox"/> Short Term Disability <input type="checkbox"/> I decline coverage for myself <input type="checkbox"/> I decline coverage for my dependents Reason: <input type="checkbox"/> covered under another plan <input type="checkbox"/> other:

B. FAMILY INFORMATION

- List all family members to be covered. Write name as it should appear on I.D. card.
- Student status information will be required for all family members which exceed the age stated for dependents in the Master Group Contract or Policy.
- Indicate dependent address (if different) in the space provided below.

	First Name	M.I.	Last Name	Social Security Number	Relationship	Sex	Birthdate	Full-Time College Student
01	Address:				SPOUSE	M F	/ /	
02	Address:					M F	/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO School Name:
03	Address:					M F	/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO School Name:
04	Address:					M F	/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO School Name:
05	Address:					M F	/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO School Name:

C. OTHER INSURANCE INFORMATION (THIS SECTION MUST BE COMPLETED)

On the day your coverage begins will you or any family members, including those not listed above, be covered by other insurance or Medicare?
Use extra paper if more than one additional policy will be in force. YES NO If yes, fill out this section.

Coverage type: <input type="checkbox"/> Medical Insurance <input type="checkbox"/> Dental Insurance <input type="checkbox"/> Medicare (see below)	<input type="checkbox"/> Life Insurance <input type="checkbox"/> STD Insurance	Insurance Company Name and Phone Number	Policy Number
Policy Coverage Dates _____ to _____	Name of Policyholder	Policyholder's Birthdate	Family Members Covered
Policyholder's Employer: Name		Address	Phone Number
Names of family members covered by Medicare	Medicare Claim Number	Part A Effective Date	Part B Effective Date
		Is Medicare eligibility due to: <input type="checkbox"/> Kidney failure <input type="checkbox"/> Disability	

D. SIGNATURE (THIS FORM MUST BE SIGNED)

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give IBA Health and Life Assurance Company and the employer or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my and/or my dependents' coverage.

NOTICE OF ENROLLMENT RIGHTS: I understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

X
Employee Signature _____ Date Signed _____

E. FOR EMPLOYER USE ONLY

Full Company Name	Branch/Division	Group Number
Employee I.D. Number	Hire Date / /	Effective Date / /
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	<input type="checkbox"/> Union <input type="checkbox"/> Non-Union	<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly
Annual Salary	Avg Hrs worked/wk	Approved By (Signature) X
<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire	<input type="checkbox"/> Other (specify) _____ (date)	<input type="checkbox"/> Late Enrollment
		Date

FOR INSURANCE COMPANY USE ONLY

Group Number	Effective Date(s)	County	Rate Class	Department	Duplicate	Date Received
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