

MAIL TO:  
8025 North Point Boulevard, Suite 100  
Winston-Salem, North Carolina 27106

## STATUS CHANGE FORM

EMPLOYER _____		SF # _____	
SUBSCRIBER / EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL) _____		SOCIAL SECURITY NUMBER _____	
DATE OF BENEFIT TERMINATION MO.      DAY      YEAR		BEGINNING DATE NOT ACTIVELY-AT-WORK MO.      DAY      YEAR	
NOT ACTIVELY-AT-WORK DUE TO:			
<input type="checkbox"/> COMPANY APPROVED LEAVE OF ABSENCE _____		<input type="checkbox"/> SICK/ACCIDENT LEAVE _____	
<input type="checkbox"/> FAMILY LEAVE _____		<input type="checkbox"/> TOTAL DISABILITY _____	
<input type="checkbox"/> REDUCTION OF AAW HOURS _____		<input type="checkbox"/> OTHER _____	
COVERAGE BEING CHANGED: <input type="checkbox"/> DENTAL			
MY COVERAGE SHOULD NOW BE: <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> PARENT/CHILD <input type="checkbox"/> FAMILY <input type="checkbox"/> OTHER			
EFFECTIVE DATE OF CHANGE: _____			
TYPE OF CHANGE:			
<input type="checkbox"/> ADD	<input type="checkbox"/> DROP	RELATIONSHIP _____	SS# _____ / _____ / _____      DOB _____ / _____ / _____
<input type="checkbox"/> ADD	<input type="checkbox"/> DROP	RELATIONSHIP _____	SS# _____ / _____ / _____      DOB _____ / _____ / _____
<input type="checkbox"/> ADD	<input type="checkbox"/> DROP	RELATIONSHIP _____	SS# _____ / _____ / _____      DOB _____ / _____ / _____
<input type="checkbox"/> ADD	<input type="checkbox"/> DROP	RELATIONSHIP _____	SS# _____ / _____ / _____      DOB _____ / _____ / _____
IF SPOUSE ADDED, DATE OF MARRIAGE MO.      DAY      YEAR		NAME CHANGE _____	
NEW BENEFICIARY _____		RELATIONSHIP _____	
NEW CONTINGENT _____		RELATIONSHIP _____	
PLEASE REPLACE MY I.D. CARD <input type="checkbox"/> DRUG <input type="checkbox"/> MEDICAL		ADDRESS CHANGE <input type="checkbox"/> YES <input type="checkbox"/> NO	
NEW ADDRESS, IF APPLICABLE:			
STREET _____		CITY _____ STATE _____ ZIP _____	
CONTINUANCE OF CHILD UNDER DISABLE STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
ADOPTION OR CHILD SUPPORT ORDER (ATTACH SUPPORTING DOCUMENTATION)			
ADOPTION: _____ IS AN ADOPTED CHILD(REN) OR HAS BEEN PLACED WITH PARTICIPANT FOR ADOPTION. DATE OF PLACEMENT FOR ADOPTION OR DATE ADOPTION WAS FINAL, WHICHEVER OCCURRED FIRST: _____			
CHILD SUPPORT ORDER: A CHILD SUPPORT ORDER HAS BEEN ISSUED FOR _____ <span style="float:right; font-size: small;">(NAME OF CHILD/CHILDREN)</span>			
(THE SUBSCRIBER/EMPLOYEE WILL BE NOTIFIED ONCE A DETERMINATION HAS BEEN MADE AS TO WHETHER THE CHILD DOES OR DOES NOT QUALIFY FOR COVERAGE UNDER THE PLAN.)			
OTHER CHANGES: _____			

EMPLOYER \_\_\_\_\_ DATE \_\_\_\_\_

**•• Please be aware of COBRA requirements to be followed in dropping coverage.**

SUBSCRIBER / EMPLOYEE \_\_\_\_\_ DATE \_\_\_\_\_