CHANGE FORM

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

IBA HEALTH PLAN℠
IBA Health and Life Assurance Company

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 ☐ Death ☐ Moved outside service area ☐ Employee now ineligible ☐ Dissatisfied ☐ Dependent now ineligible ☐ Other:

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 ☐ Delete ☐ Change	Address (if different):		M F	/ /		
☐ Add ☐ Delete ☐ Change	Address (if different):		M F	/ /	☐ YES ☐ NO School Name & Location:	
☐ Add ☐ Delete ☐ Change	Address (if different):		M F	/ /	☐ YES ☐ NO School Name & Location:	

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: ☐ Medical Insurance ☐ Dental Insurance ☐ Medicare (see below)	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: ☐ Kidney failure ☐ 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		