



PARTICIPANT STATUS CHANGE FORM

TYPE OF CHANGE <input type="checkbox"/> Name Change <input type="checkbox"/> Delete Disability Coverage <input type="checkbox"/> Address Change <input type="checkbox"/> Delete Health Coverage <input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dental Coverage <input type="checkbox"/> Delete Dependant <input type="checkbox"/> Delete Life Coverage <input type="checkbox"/> Terminate Coverage <input type="checkbox"/> Other _____	TYPE COVERAGE REQUESTED <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Family	REASON FOR CHANGE <input type="checkbox"/> Marriage ** <input type="checkbox"/> Overage Dependent <input type="checkbox"/> Death ** <input type="checkbox"/> Layoff <input type="checkbox"/> Terminate Employment ** <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Divorce ** <input type="checkbox"/> Return of Alternate Insurance <input type="checkbox"/> Birth ** <input type="checkbox"/> Disability <input type="checkbox"/> Adoption ** <input type="checkbox"/> Other _____ ** DATE OF EVENT _____
EFFECTIVE DATE OF CHANGE _____		

GENERAL INFORMATION	
Employer Name _____	Group Number _____
Employee's Name (Last Name, First Name, Middle Initial) _____	FBA Employee ID _____

A copy of the court order must be attached for dependents in court-ordered custody or guardianship of the Employee

LIST ELIGIBLE DEPENDENTS TO BE COVERED (PLEASE PRINT) If more space is required, attach a separate sheet with additional information

Name(s) to be deleted (Last, First, Middle Initial) _____	Date of Birth _____	Name(s) to be deleted (Last, First, Middle Initial) _____	Date of Birth _____
Reason for Deletion <input type="checkbox"/> Age <input type="checkbox"/> Divorce <input type="checkbox"/> Marriage <input type="checkbox"/> Death <input type="checkbox"/> Other – Please Explain: _____		Reason for Deletion <input type="checkbox"/> Age <input type="checkbox"/> Divorce <input type="checkbox"/> Marriage <input type="checkbox"/> Death <input type="checkbox"/> Other – Please Explain: _____	
Change in Beneficiary (Last, First, Middle Initial) _____	Date of Birth _____	Relationship _____	<input type="checkbox"/> Add <input type="checkbox"/> Delete
Change in Beneficiary (Last, First, Middle Initial) _____	Date of Birth _____	Relationship _____	<input type="checkbox"/> Add <input type="checkbox"/> Delete
<input type="checkbox"/> Name Change	Change Name From: _____ To: _____		
<input type="checkbox"/> Address Change	New Address (Street, City, County, State, Zip) _____		Phone Number _____
<input type="checkbox"/> Other			

OTHER CARRIER LIABILITY INFORMATION – THIS SECTION MUST BE COMPLETED

On the day this coverage begins, will you or any dependants enrolling in this Plan be covered by any other group insurance or Medicare? If yes, fill out the appropriate section(s) below. If more space is required, attach a separate sheet with additional information.

HEALTH			DENTAL			MEDICARE	
Participant Member's Name		Date of Birth	Participant's Member's Name		Date of Birth	Beneficiary Name	
Employment Status		Name of Employer	Employment Status		Name of Employer	Entitlement Reason	
<input type="checkbox"/> Active <input type="checkbox"/> Retired			<input type="checkbox"/> Active <input type="checkbox"/> Retired			<input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Other Disability	
Policy #	Effective Date	Type of Coverage	Policy #	Effective Date	Type of Coverage	<input type="checkbox"/> Age 65 or older <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Other Disability	
		<input type="checkbox"/> Single <input type="checkbox"/> Family			<input type="checkbox"/> Single <input type="checkbox"/> Family	Medicare HIC Number	
Name of Insurance Company		Phone #	Name of Insurance Company		Phone #	Medicare HIC Number	
City, State and Zip Code of Claims Center			City State and Zip Code of Claims Center			Part A Effective Date	
Does the above insurance cover "all" family including you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please list the names of all dependents covered?			Does the above insurance cover "all" family including you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please list the names of all dependents covered?			Part B Effective Date	

I certify that the above information is complete and true and that those listed as such are legal dependents. I also authorize payroll deduction(s) from my salary for my contribution toward the cost of any of the Plan coverages. Pre-existing conditions will not be covered for twelve to eighteen months unless proof of Continuation of medical coverage is provided. Any person who knowingly and with intent to injure, defraud, or deceive any benefit plan, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree

Employee Signature

Date

Employer Signature

Date

PRIVACY/CONFIDENTIALITY NOTE: The information contained on this form is legally privileged and confidential. It is intended only for the use of the employer and/or claims administrator. If you are not the intended recipient of this form, you hereby are notified that any dissemination, distribution, downloading or copying of the contents is strictly prohibited. If you are the intended recipient(s) you will need to secure the contents conforming to all applicable state and/or federal requirements relating to the privacy and confidentiality of such information, including the HIPAA Privacy guidelines. FBA does not accept any liability for any errors or omissions in the contents of this form.

A COPY OF THIS COMPLETED FORM SHOULD BE RETAINED FOR YOUR FILES AND THE ORIGINAL RETURNED TO YOUR HUMAN RESOURCES OFFICE OR YOUR BENEFITS ADMINISTRATOR

THEN MAIL OR FAX THE COMPLETED SIGNED FORM TO: **FIRST BENEFIT ADMINISTRATORS, INC**
 13080 Belcher Road South, Suite A
 Phone: 727.530.4144 ♦ Fax: 727.535.3977
www.firstbenefitadmin.com