Polk County Health/Dental/Vision
Insurance Change Form

Complete both Page 1 and Page 2

EMPLOYEE INFORMATION

Name (Last, First, MI):	Social Security Number:

Your New Name (Last, First, MI)			
Your new address (street)	**(city)**	**(state)**	**(ZIP)**

COMPLETE FOR ADDING, CANCELING OR CHANGING* A COVERAGE

Coverage:

☐ **Change from Single to Family Coverage** ☐ **Change from Family to Single Coverage**

Health	☐ Add	☐ Employee	☐ Spouse	☐ Children
	☐ Cancel	☐ Employee	☐ Spouse	☐ Children
Dental	☐ Add	☐ Employee	☐ Spouse	☐ Children
	☐ Cancel	☐ Employee	☐ Spouse	☐ Children
Vision	☐ Add	☐ Employee	☐ Spouse	☐ Children
	☐ Cancel	☐ Employee	☐ Spouse	☐ Children

REASON FOR ADDING A COVERAGE OR DEPENDENT

☐ marriage ☐ loss of other group coverage* ☐ change in job status ☐ birth/adoption ☐ court order (attach a copy)

☐ other _____ Date of event _____

*Name of prior dental carrier _____ Date coverage ended _____

*Name of prior health carrier _____ Date coverage ended _____

* Provide proof of loss of involuntary loss of coverage (e.g. letter from HR department or insurance carrier)

REASON FOR CANCELING A COVERAGE OR DEPENDENT

☐ age limit ☐ spouse's group coverage* ☐ individual insurance

☐ Medicare ☐ divorce (attach a copy of the First, Last and page regarding insurance benefits of the divorce decree)

☐ other _____ Date of event _____

*Provide proof that dependent is covered under another health plan (e.g. copy of insurance card or letter)

COMPLETE FOR ADDING OR CANCELING A DEPENDENT (include last name if different from the employee)

Spouse's name	Birth Date		Social Security number
		☐ male ☐ female	

Name(s) of child(ren)	Birth date		Social Security number	
		☐ male ☐ female		☐ Step or Foster Child
		☐ male ☐ female		☐ Step or Foster Child
		☐ male ☐ female		☐ Step or Foster Child
		☐ male ☐ female		☐ Step or Foster Child

PLEASE COMPLETE THE FOLLOWING ONLY IF ADDING HEALTH INSURANCE COVERAGE

PRIMARY CARE PHYSICIAN (PCP) DESIGNATION – Each employee and member must designate a PCP before insurance cards can be generated for Health Insurance. *It is not necessary to designate a primary Dentist.*				
Full Name (First, Last)	Provider Number	PCP Name (First and Last Name)	PCP Address (Location where services will be received)	Are you an established patient?
Spouse				☐ Yes ☐ No
Dependent				☐ Yes ☐ No
Dependent				☐ Yes ☐ No
Dependent				☐ Yes ☐ No
Dependent				☐ Yes ☐ No

OB/GYN DESIGNATION – Female members may designate an OB/GYN *in addition to a PCP*				
Full Name (First, Last)	OB/GYN Provider Number	OB/GYN Name (First and Last Name)	OB/GYN Address	Are you an established patient?
Spouse				☐ Yes ☐ No
Dependent				☐ Yes ☐ No
Dependent				☐ Yes ☐ No
Dependent				☐ Yes ☐ No
Dependent				☐ Yes ☐ No

I understand and agree with the following statements:

- My dependents are not eligible for any coverage for which I am not covered.
- My dependents, including stepchildren, foster children and those over the maximum age, are eligible for coverage based on policy provisions. Eligibility for my dependents over the maximum age will be verified when claims are submitted.
- If the eligibility of my dependents changes (divorce, age limit, dependent status) I will notify my employer within 31 days of the change to remove the dependent from the applicable insurance plan(s). I understand that if I fail to notify my employer, I may be held responsible for any claims paid on behalf of the ineligible dependent.
- If I cancel dental coverage, I and/or my dependents may enroll at a later date; however, enrolling late will affect the level of benefits provided.
- If the group policy requires that I make contributions, I authorize my employer to deduct them from my pay.
- If I knowingly provide false or misleading information, I may be guilty of insurance fraud, which is punishable by law.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

I declare that the information I have completed on this change form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval.

Your Signature X_____ **Date Signed** _____