

CHANGE REQUEST FORM



INSURANCE DESIGN ADMINISTRATORS
PO Box 875, Oakland NJ 07436

Social Security Number.	Employee's Last Name	First Name	Middle Initial
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The following changes should be made in my group insurance coverage:

CHANGE MY NAME

From: _____ Marriage Divorce

To: _____ Correction Legal

CHANGE MY COVERAGE

From: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Husband/Wife <input type="checkbox"/> Parent/Child	To: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Husband/Wife <input type="checkbox"/> Parent/Child
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If adding dependents, complete the following:

Spouse's First Name		Spouse's Social Security Number	
Spouse's Date of Birth		Spouse's Employer (Company Name)	
Spouse's Employer Address		Spouse's Employer Telephone Number	
Spouse's Health Insurance Company		Policy Number	Does Spouse Have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No
List those dependents (children) you wish covered under your policy. If more space is needed use reverse side.			
Last Name	First Name	Date of Birth	
Last Name	First Name	Date of Birth	
Last Name	First Name	Date of Birth	

If change is a result of a recent marriage, provide date of marriage _____

If terminating coverage on dependents, provide reason _____

CHANGE MY ADDRESS

From: _____

To: _____

OTHER CHANGES - Explain

I hereby declare that all the statements made are, to the best of my knowledge and behalf, true and complete.

Date: _____ Employee Signature _____

EMPLOYER USE ONLY	
Plan Number _____	Group Name _____
Effective Date _____	Signature _____