CHANGE REQUEST FORM

INSURANCE DESIGN ADMINISTRATORS
PO Box 875, Oakland NJ 07436

Social Security Number.	Employee's Last Name	First Name	Middle Initial

The following changes should be made in my group insurance coverage:

CHANGE MY NAME

From: _____ ☐ Marriage ☐ Divorce

To: _____ ☐ Correction ☐ Legal

CHANGE MY COVERAGE

From: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child

To: ☐ Single ☐ Family ☐ Husband/Wife ☐ Parent/Child

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?** ☐ **Yes** ☐ **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 _____