ASCA HEALTH PLAN CHANGE FORM

COMPANY INFORMATION

Company Name: _____

Contact Name: _____ Title / Role: _____

Phone _____ `Email: _____

Contact Signature _____

EMPLOYEE INFORMATION

Name: _____

Address _____ City: _____ State: _____ Zip: _____

DOB: ___ - ___ - ___ SSN: ___ - ___ - ___

Employee Signature: _____

Gender: ◯ Male ◯ Female

REASON FOR BENEFIT CHANGES

You must submit legal documentation of the event along with this form.

Event:

◯ Marriage

◯ Divorce

◯ Birth or Adoption of Child

◯ Dependent Reached 26 Years of Age

◯ Dependent lost or acquired benefits

◯ Other:

Date of Event: ___ / ___ / ___

MEMBERSHIP INFORMATION

Please indicate below the plan(s) in which the subscribers are to be enrolled/removed. The employee's information only needs to be listed if there is to be a change in his/her enrollments.

Name: _____ Relationship to Employee: ◯ Spouse ◯ Child

Gender: ◯ Male ◯ Female DOB: ___/___/___ SSN: ___-___-___

Please select which plan(s) this person should be enrolled in or removed from:

Medical: ◯ Premier Plan ◯ Value Plan ◯ Decline / Remove Coverage

Dental: ◯ Enhanced Plan ◯ Basic Plan ◯ Decline / Remove Coverage

Vision: ◯ Premier Plan ◯ Decline / Remove Coverage

Name: _____ Relationship to Employee: ◯ Spouse ◯ Child

Gender: ◯ Male ◯ Female DOB: ___/___/___ SSN: ___-___-___

Please select which plan(s) this person should be enrolled in or removed from:

Medical: ◯ Premier Plan ◯ Value Plan ◯ Decline / Remove Coverage

Dental: ◯ Enhanced Plan ◯ Basic Plan ◯ Decline / Remove Coverage

Vision: ◯ Premier Plan ◯ Decline / Remove Coverage

Name: _____ Relationship to Employee: ◯ Spouse ◯ Child

Gender: ◯ Male ◯ Female DOB: ___/___/___ SSN: ___-___-___

Please select which plan(s) this person should be enrolled in or removed from:

Medical: ◯ Premier Plan ◯ Value Plan ◯ Decline / Remove Coverage

Dental: ◯ Enhanced Plan ◯ Basic Plan ◯ Decline / Remove Coverage

Vision: ◯ Premier Plan ◯ Decline / Remove Coverage