ENROLLMENT CHANGE FORM

Group Name: ____________________________

Location: ______________________________

Lake County Government Center
2293 North Main Street - Apt. A-304
Crown Point, IN 46307
Phone: 1-219-755-3211

Complete this section in full; incomplete information delays processing.

Employee Social Security Number	Employee Name (As appears on ID Card)	Requested Effective Date of Change

Type of Change ➤ ☐ NAME ☐ ADDRESS ☐ COVERAGE ☐ DEPENDENT ☐ BENEFICIARY ☐ OTHER (Specify: ____________________)

Complete only items to be changed.

EMPLOYEE ADDRESS/PHONE CHANGES

Street Address		
City	State	Zip
Home Telephone ( )	Work Telephone ( )	

COVERAGE CHANGES

FROM	TO	TYPE OF COVERAGE	Give Date of Marriage or Divorce
☐	☐	Employee Only	
☐	☐	Employee/Spouse	
☐	☐	Employee/Children Only	
☐	☐	Employee/Family	
☐	☐	Cancel Coverage	

CHANGE MY NAME TO:	Last Name	First Name	Middle Initial

LIST BELOW ANY DEPENDENTS TO BE ADDED OR TERMINATED AS A RESULT OF THIS COVERAGE CHANGE

CHANGE MY BENEFICIARY TO: **(THIS CHANGE CANCELS ALL PREVIOUS DESIGNATIONS)**

Beneficiary Last Name	Beneficiary First Name	Middle Initial	Beneficiary Relationship to Employee

Indicate for each individual "C" if Change, "A" if Addition or "T" if Termination.

	FULL NAME / Relationship to Employee	SEX M/F	DATE OF BIRTH Mo	Day	Yr	SOCIAL SECURITY NUMBER	INDICATE YES/NO FOR EACH ITEM: Disabled	Other Health Coverage	CARRIER (Include Medicare) / EMPLOYER (if applicable)
	Employee Name								
	Spouse Name								
	1. Dependent Name Relationship								
	2. Dependent Name Relationship								
	3. Dependent Name Relationship								

I authorize the preceding changes for myself and any eligible members of my family listed above. I also authorize my employer to deduct from my earnings the amount required to cover my share of payment for this Plan. I further authorize anyone providing services to me or my dependents to release to this Plan any information or medical records relating to those services. I certify that the information contained in this form is true and complete to the best of my knowledge. I have read the terms and conditions for enrolling a dependent over the age of 19 in the medical plan. I further understand the coverage for my dependent will terminate upon attainment of age 26. I also understand that if a spouse is employed, and his/her employer offers medical coverage for which he/she is eligible, he/she must be covered by his/her employer's plan as primary.

Employee Signature	Date
______________________________	__________