UniCare®
A Healthy Dose of Innovation®

Reset Form

Employee Request for Change

1. Employer Information *(To be completed by Employer.)*

EMPLOYER NAME	POLICY/CASE NO.

2. Employee Information

EMPLOYEE NAME (Last, First, MI)	SOCIAL SECURITY NUMBER

3. Subscriber Information Change

CHANGE EMPLOYEE'S NAME TO	REASON FOR CHANGE	DATE OF CHANGE

RESIDENT ADDRESS (Street, City, State, Zip)

DEPT #	BILL GROUP/BILL REFERENCE NO.	BILL SUBGROUP/UNIT/SUBSORT NO.	CLASS	CLAIM CATEGORY

4. Addition of Employee/Dependent Coverage

☐ Late Enrollee ☐ HIPAA Special Enrollee*

(Complete dependent information if adding a specific dependent for health coverages, or adding dependent health coverages)

INDICATE COVERAGES BEING ADDED

☐ EE Medical ☐ Dep Medical ☐ EE Dental ☐ Dep Dental ☐ EE Vision ☐ Dep Vision ☐ EE Drugs ☐ Dep Drugs
☐ EE Life/AD&D ☐ EE Supp Life/AD&D ☐ Dep Life ☐ LTD ☐ Weekly Dis

Dependent Name (First, MI, Last Name)	Relationship	Effective Date	Sex M-Male F-Female	Date of Birth (mo., day, yr.)	Full-time Student (if age 19 or older)	Dependent Social Security Number
	Spouse		☐ M ☐ F		☐ Y ☐ N	
	Child		☐ M ☐ F		☐ Y ☐ N	
	Child		☐ M ☐ F		☐ Y ☐ N	
	Child		☐ M ☐ F		☐ Y ☐ N	

If child is adopted, please provide date legally adopted. _____ Please submit a copy of the adoption paperwork.

If adding spouse for the first time, please provide date of marriage _____.

5. Termination of Employee/Dependent Coverage

(Complete dependent information if terminating a specific dependent for health coverages, or terminating all dependent health coverages)

INDICATE COVERAGES BEING TERMINATED

☐ EE - All coverage's ☐ EE Medical ☐ Dep Medical ☐ EE Dental ☐ Dep Dental ☐ EE Vision ☐ Dep Vision ☐ EE Drugs ☐ Dep Drugs
☐ EE - FSA ☐ EE - HSA ☐ EE Life/AD&D ☐ EE Supp Life/AD&D ☐ Dep Life ☐ LTD ☐ Weekly Dis

Dependent Name (First, MI, Last Name)	Relationship	Termination Date	Reason
	Spouse		
	Child		
	Child		
	Child		

☐ *Check here if you are declining coverage because of other health coverage. If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends.*

***HIPAA Special Enrollees:** If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption, regardless of whether you had other health coverages.*

6. Beneficiary Change *(Use form GA3434 for multiple beneficiaries.)*

NAME OF NEW BENEFICIARY	BENEFICIARY ADDRESS (Number & Street, City, State, Zip)	RELATIONSHIP

7. Employee Authorization

I hereby request these changes for the insurance for which I am eligible for under the group policy or policies issued to the policyholder by UniCare Life & Health Insurance Company. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such insurance.

EMPLOYEE'S SIGNATURE	DATE

SAVE