ENROLLEE CHANGE FORM

Employer:_____

(Please submit applicable pages only)

HRA or HYBRID PLAN

NEW ENROLLEE - Complete below OR send a copy of the carrier's enrollment form

Date Enrolled in Group Health Plan: _____/_____/_____

Employee's Name (as it appears on the social security card)_____

SSN _____/_____/_____ Gender: Male or Female (circle one)

Employee's Department: *(where applicable)* _____

Mailing Address _____

City _____ State _____ Zip _____

Email Address _____@_____._____

DOH _____/_____/_____ DOB _____/_____/_____ Phone #: _____

Medicare Primary or Secondary? (circle one if applicable) Medicare ID #: _____

Tier of Coverage: EMPLOYEE ONLY, EMPLOYEE/SPOUSE, EMPLOYEE/CHILD, FAMILY *(please circle one when applicable)*

FOR MEDICARE SECONDARY PAYER REQUIREMENTS:
IF EMPLOYEE COVERS DEPENDENTS, COMPLETE AND SEND PAGE 4 OF THIS FORM

ORDER CARD FOR SPOUSE AND/OR DEPENDENT *(when applicable)*

Spouse's Name: _____ SSN: _____

Dependent's Name: _____SSN: _____

_____ _____
Employer Representative Signature (required) Date

Innovative Employee Benefits, Inc.
PO Box 470257, Charlotte, NC 28247 Fax: 704-341-5984 TF 866-541-5984 Phone: 704-341-5981 TF 866-541-5981

ENROLLEE CHANGE FORM

Employer:_____

(Please submit applicable pages only)

NOTIFICATION OF TERMINATION

Employee: _____ SSN _____/_____/_____

Employee's Location: *(when applicable)* _____

Date terminated from Group Health Plan: _____/_____/_____

CHANGE TO CURRENT ENROLLEE

Employee: _____ SSN _____/_____/_____

Employee's Division: *(where applicable)* _____

Change Name to: _____
Change Address to: _____
Change Email address to: _____

Change in Tier of Coverage Effective: _____/_____/_____
If adding or deleting dependents, please also complete and attach page 4 of this form

Medicare Primary/Secondary Effective _____/_____/_____ *(circle Primary or Secondary)*
Medicare ID # _____

From: EMPLOYEE ONLY EMPLOYEE/SPOUSE EMPLOYEE/CHILD FAMILY
To: EMPLOYEE ONLY EMPLOYEE/SPOUSE EMPLOYEE/CHILD FAMILY

COBRA ELECTION – RE-ENROLL *(this is re-enrollment in the medical plan)*

Employee: _____ SSN _____/_____/_____

Employee's Location: *(where applicable)* _____

Date of original termination: _____/_____/_____

_____ _____
Employer Representative Signature (required) Date

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ENROLLEE CHANGE FORM

Employer:_____

(Please submit applicable pages only)

FLEX ELIGIBILITY

NOTIFICATION OF BENEFIT TERMINATION

Employee: _____ SSN _____/_____/_____

Employee's Location: *(when applicable)* _____

Flex Benefit Termination date: _____/_____/_____

Amount of last reduction $_____

Year-to-date amount of deductions:
Unreimbursed Medical $_____ Dependent (Day) Care $_____

Please change the benefit election as follows: *(if you would like to consult on the IRS rules and regulations for making changes to a Flex plan pledge, give us a call)*

	From:	*To:*
Non-reimbursed Medical	$_____ per pay period	$_____ per pay period ***(increase only)***
Dependent Daycare	$_____ per pay period	$_____ per pay period

Per Pay Period election change will take effect on _____/_____/_____

COBRA ELECTION – RE-ENROLL *(this is re-enrollment in the Flex plan)*

Employee: _____ SSN _____/_____/_____

Employee's Location: *(where applicable)* _____

Date of original termination: _____/_____/_____

_____ _____
Employer Representative Signature (required) Date

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ENROLLEE CHANGE FORM

Employer:_______________________________

(Please submit applicable pages only)

DEPENDENT ELIGIBILITY (circle one: enrollment OR termination)

Effective Date ________/________/________

Spouse's Name (as it appears on the social security card)____

Spouse's SSN _____/_______/_______ Spouses's DOB: _____/_______/_______ Gender: M or F

Medicare Primary or Secondary *(circle one)* Medicare ID #:________________________________

Dependent's Name (as it appears on the social security card____

Dependent's SSN: ______/_______/_______ Dependent's DOB: _____/_______/_______ Gender: M or F

Medicare Primary or Secondary *(circle one)* Medicare ID #:________________________________

Dependent's Name (as it appears on the social security card____

Dependent's SSN: ______/_______/_______ Dependent's DOB: _____/_______/_______ Gender: M or F

Medicare Primary or Secondary *(circle one)* Medicare ID #:________________________________

Dependent's Name (as it appears on the social security card____

Dependent's SSN: ______/_______/_______ Dependent's DOB: _____/_______/_______ Gender: M or F

Medicare Primary or Secondary *(circle one)* Medicare ID #:________________________________

Dependent's Name (as it appears on the social security card____

Dependent's SSN: ______/_______/_______ Dependent's DOB: _____/_______/_______ Gender: M or F

Medicare Primary or Secondary *(circle one)* Medicare ID #:________________________________
(attach additional pages is necessary)

____ ________________________________

Employer Representative Signature (required) Date

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