



GROUP INSURANCE CHANGE FORM REQUEST

SET SEG • 415 W. Kalamazoo • Lansing, Michigan 48933 • 1-800-292-5421

INSTRUCTIONS: Please indicate only the change(s) you are reporting at this time. This Change Form Request will facilitate the change(s). A new application is not necessary. The change will not be valid unless this form is signed and dated by the employee.

FOR SET FRINGE BENEFIT PLANS - MACOMB INTERMEDIATE SCHOOL DISTRICT - ACCOUNT #: 50000

EMPLOYEE INFORMATION:

Name _____ Social Security No. _____
LAST FIRST

SECTION I: GENERAL

a) **NAME CHANGE:** To: _____
LAST FIRST

b) **ADDRESS CHANGE:** To: _____
STREET NAME & NUMBER

CITY STATE ZIP

c) **MARITAL STATUS CHANGE:** Married; Date _____ Divorced; Date _____ Legally Separated; Date _____

d) **JOB TITLE OR POSITION CHANGE:** To: _____ Date _____

e) **CANCELLATION OF EMPLOYER-PROVIDED INSURANCE PLAN DATE _____ COMPLETE SECTION II BELOW**

SECTION II: DEPENDENT STATUS CHANGE

Name (first)	Last (if different)	Sex M F	Social Security #	Birthdate MM/DD/YY	Relationship	Add	Delete	Reason* (see below)	Insurance Affected (Medical, Dental, Vision)	Other Insurance Yes No

*Please insert the corresponding number as it applies to this change: (1) Marriage (2) Divorce (3) Employment (4) Continue Education (5) Death (6) Birth (7) Other (please explain) _____

If you named a child, above, whose birth parents are divorced or separated, is there a court order stating which parent is responsible for providing health insurance (Please attach a copy of the court order) Yes — If yes, Father Mother No

Name of Subscriber _____ Social Security No. _____ Date of Birth _____ Employer _____

Name of Medical Insurance Co. _____ Name of Dental Insurance Co. _____ Name of Vision Insurance Co. _____

SECTION III: ELIGIBLE FOR MEDICARE

My dependent, _____, is eligible for Medicare Plans A and B, prior to the attainment of age 65.
FULL NAME

Medicare coverage is effective as of _____
MONTH DAY YEAR

AUTHORIZATION: I hereby understand that I am authorizing SET, Inc. to revise my Group Insurance coverage record(s) in accordance with the Change Request Form designation. Further, the effective date of the request(s) will be determined by my eligibility and the underwriting policies of the Union Security Insurance Company, Blue Cross and Blue Shield of Michigan or other insurers as applicable, and any additional contribution required may be deducted from my earnings.

Date _____ Signature of Employee _____

Name of Employer _____

SET USE ONLY: Effective Date _____ Approved By _____ Date _____