Hog Slat/BCBSNC Health Plan Change Form

Subscriber/Employee Name (Last, First, Middle Initial)	Social Security Number	Employee Number

BENEFIT TERMINATION – EMPLOYER INITIATED

Date of Benefit Termination	Beginning Date not Actively At Work
Mo. Day Year	Mo. Day Year

Not actively at work due to:

- o Company approved leave of absence beyond 3 months
- o Family leave (after 12 weeks expired)
- o Reductions of AAW Hours (must be less than 17 hrs./week)
- o Sick/Accident leave
- o Total disability
- o Other: _____

BENEFIT CHANGE OR TERMINATION – EMPLOYEE INITIATED **EFFECTIVE DATE OF CHANGE: _____**

Please indicate the qualifying event:

o Marriage	Date:_____	o Open Enrollment	Date: _____	o End of Other overage	Date:_____
o Birth	Date:_____	o Dep. Open Enroll	Date: _____	o Divorce	Date:_____
o Medicare	Date: _____	o Medicaid	Date: _____	o Death	Date: _____

ADD OR DROP SELF OR DEPENDENTS

o Add	o Drop _____	Relationship: _____	SS#____/___/____	DOB:	Gender:
o Add	o Drop _____	Relationship: _____	SS#____/___/____	DOB:	Gender:
o Add	o Drop _____	Relationship: _____	SS#____/___/____	DOB:	Gender:
o Add	o Drop _____	Relationship: _____	SS#____/___/____	DOB:	Gender:

NAME CHANGE

Please indicate new name: First_____ Middle_____ Last_____

ADDRESS CHANGE - Please write new address below.

Address:	City:	State:	Zip:

TAX STATUS CHANGE – Please indicate if you want to change your benefit tax status.

Do you want your benefit premiums taken out of your paycheck pre-tax or after tax?	o Pre-Tax	o After Tax

Dependent Adoption or Foster Care: Attach supporting documentation. The subscriber/employee will be notified once a determination has been made as to whether the child does or does not qualify for coverage under the plan.

(Child's Name)_____ is an adopted child(ren) or has been placed with participant for adoption or foster care. Date of placement for adoption, date adoption was final, or date of foster care placement, whichever occurred first: _____

CHILD SUPPORT ORDER Attach supporting documentation. The subscriber/employee will be notified once a determination has been made as to whether the child does or does not qualify for coverage under the plan.

A child support order has been issued for:

(Name of Child or Children) _____

_____ _____

Plan Representative – Hog Slat **Date**

_____ _____

Subscriber/Employee **Date**

Please be aware of COBRA requirements & timeframes to be followed when changing coverage.