CHANGE REQUEST

Send to:

ASSURECARE®
Assured Access Health Systems Management
1742 Georgetown Road Suite E
Hudson, OH 44236
Phone: (330)528-3929
Fax: (330) 342-1642

Todays Date: _____ / _____ / _____

- ☐ EMPLOYEE TERMINATION
- ☐ DEPENDENT TERMINATION
- ☐ ADD DEPENDENTS
- ☐ ADDITIONAL FORMS ATTACHED
- ☐ NAME CHANGE
- ☐ CHANGE OF ADDRESS
- ☐ LIFE INSURANCE CHANGE
- ☐ OTHER (specify in remarks section)

Part A Employee Information / Plan Information

Employee Name	Employer Name
Employee Soc. Sec. #	Group Number

Part B Termination Information

☐ EMPLOYEE ☐ DEPENDENT	☐ EMPLOYEE ☐ DEPENDENT
Name	Name
Soc. Sec. #	Soc. Sec. #
Coverage Termination Date	Coverage Termination Date
Reason	Reason
Plan Coverage	Plan Coverage

For further terminations and additional dependents please attach extra forms

Part C Additional Dependents

Dependent Name			Dependent Name		
Birth Date		Sex ☐ M ☐ F	Birth Date		Sex ☐ M ☐ F
Social. Security. #			Social Security. #		
Newborn: ☐ Yes ☐ No	COPCC Form Attached: ☐ Yes ☐ No		Newborn: ☐ Yes ☐ No	COPCC Form Attached: ☐ Yes ☐ No	
Effective Date		Qualifying Event Date	Effective Date		Qualifying Event Date

Part D Life Insurance Change

Life Volume Amount/Change (new amount)		Life Insurance Termination Date	
Beneficiary Change (new beneficiary name)		Date of Life Insurance Change	

Part E Name/Address Change

NAME CHANGE (new name)				
CHANGE OF ADDRESS (new address)	Street Address	City	State	Zip

Part F Remarks

EMPLOYEE SIGNATURE	▶	DATE
EMPLOYER SIGNATURE	▶	DATE

NOTE: Employee signature mandatory to change life insurance beneficiary, add or delete dependents

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