

# Simplified Benefits Administrators Enrollment Change Letter



Employer Name: \_\_\_\_\_ Group Number: \_\_\_\_\_ Date of Hire/Rehire: \_\_\_\_\_

Please print, using blue or black ink.									
<b>Employee Information</b>									
Last Name			First Name			Middle Initial			
Social Security Number		Date of Birth		Gender		Phone			
Home Street Address				City		State		Zip	
Mailing Street Address (if different than above)				City		State		Zip	
<b>Select Enrollment / Change Reason</b>									
<b>Effective Date:</b> _____									
Reason for Change:					List effective date for checked box below:				
<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Reinstatement of Coverage (list start date in Employee Information section) <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change		<input type="checkbox"/> Family Status Change <input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Cancel Coverage <input type="checkbox"/> Employment Terminated <input type="checkbox"/> Loss of eligible status <input type="checkbox"/> Enrolling in COBRA <input type="checkbox"/> Other Reason for Change: _____			<input type="checkbox"/> Marriage                      Date: _____ <input type="checkbox"/> Birth / Adoption            Date: _____ <input type="checkbox"/> Divorce                        Date: _____ <input type="checkbox"/> Death                            Date: _____ <input type="checkbox"/> No Longer Eligible         Date: _____ <input type="checkbox"/> Part-time to Full-time     Date: _____ <input type="checkbox"/> Retired                         Date: _____ <input type="checkbox"/> Add Disabled Child         Date: _____				
<b>Select Coverage and Coverage Level</b>									
Elected Plan Name: _____					Division: _____				
<input type="checkbox"/> No Medical Coverage		<input type="checkbox"/> Employee Only		<input type="checkbox"/> Employee & Spouse		<input type="checkbox"/> Employee & Child(ren)		<input type="checkbox"/> Family	
<b>Please list all dependents. All fields are required.</b>									
Please provide the requested information all of your dependents who will be covered by any of the benefits chosen above. Social Security numbers are required on all members for Federal reporting purposes only. If you need more space to list additional dependents, please use a second enrollment form.									
Rel	Last Name	First Name	Sex	Date of Birth (mm/dd/yyyy)	Social Security Number	*Primary Coverage	Add/Term	Which plan?	
SP			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Term		
CH			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Term		
CH			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Term		
CH			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Term		
CH			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Term		
CH			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Term		
*Do you or any of your dependents currently have any other coverage, including Medicare?					<input type="checkbox"/> No <input type="checkbox"/> Yes; please provide the following information:				
Member Name		Employer Name		Insurance Company Name, Address & Phone number			Policy Number		Medicare A, B or both
I certify that, to the best of my knowledge, the information shown on this form is correct. This signature will serve as permission for release of personal medical information or records from any current or previous healthcare provider or facility to Simplified Benefits Administrators for the use of my healthcare plan and wellness program administration.									
<b>Employee Signature</b> _____						<b>Date</b> _____			

Submit the form to Simplified Benefits Administrators using one of the following options.

Email: [membership@simplifiedbenefitsadministrators.org](mailto:membership@simplifiedbenefitsadministrators.org)

Fax: 801.442.0945