

Simplified Benefits Administrators

Enrollment Change Letter



Employer Name: _____ **Group Number:** _____ **Date of Hire/Rehire:** _____

Please print, using blue or black ink.									
Employee Information									
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
Select Enrollment / Change Reason									
Effective Date:									
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 <input type="checkbox"/> Birth / Adoption <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> No Longer Eligible <input type="checkbox"/> Part-time to Full-time <input type="checkbox"/> Retired <input type="checkbox"/> Add Disabled Child		Date: _____ Date: _____ Date: _____ Date: _____ Date: _____ Date: _____ Date: _____		
Select Coverage and Coverage Level									
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									
Please list all dependents. All fields are required.									
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.									
Employee Signature								Date	

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

Email: membership@simplifiedbenefitsadministrators.org

Fax: 801.442.0945