

# 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>									
Change Reason:									
(Options: new hire, rehire, open enrollment, reinstatement of coverage, name change, address change, add or delete dependent due to family status change, cancel coverage, employment terminated, loss of eligible status, or enrolling in COBRA) If other, please describe.									
Event Date:									
<b>Select Coverage and Coverage Level</b>									
Elected Plan Name:									
Coverage Type:									
(Options: no medical coverage, employee only, employee + spouse, employee + children, or 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 (M/F)	Date of Birth (mm/dd/yyyy)	Social Security Number	*Primary Coverage (Yes/No)	Add/Term	Which plan?	
SP									
CH									
CH									
CH									
CH									
CH									
*Do you or any of your dependents currently have any other coverage, including Medicare? (Yes/No) If 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](mailto:membership@simplifiedbenefitsadministrators.org)

**Fax:** 801.442.0945