CHANGE FORM

(Please print in ink)

Health Benefits Trust

MEDCOST BENEFIT SERVICES℠
d/b/a MBS Third Party Administrators in California

PO Box 24042
Winston-Salem, NC 27114-4042
(336) 774-4400 Fax: (336) 760-3028
1-800-795-1023

EMPLOYEE INFORMATION

Company Name _____ Group Number _____

Employees Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____

Social Security Number_____

REASON FOR ADDITION

Effective Date _____

❑ Newborn ❑ Marriage ❑ Loss of Coverage ❑ Adoption/Custodial Date _____ ❑ Other _____

Check the coverage you wish to ADD

❑ Medical for myself | Plan Option _____
❑ Medical for my dependent(s)
❑ Dental for myself | Plan Option _____
❑ Dental for my dependent(s)
❑ Vision for myself | Plan Option _____
❑ Vision for my dependent(s)
❑ Short-term disability
❑ Long-term disability
❑ Life/Add
❑ Dependent Life
❑ Supplemental Life $_____

REASON FOR CANCELLATION

Last Day of Employment _____ Effective Date of Termination _____

❑ Termination of Employment ❑ Leave/Layoff ❑ Death ❑ Retiring Benefits ❑ Turned 19 and not a student ❑ Working less than 20 hrs per week

❑ Divorce/Separation Date _____ ❑ Other _____(you must specify reason if other)

Check the coverage you wish to CANCEL

❑ Medical for myself
❑ Medical for my dependent(s)
❑ Dental for myself
❑ Dental for my dependent(s)
❑ Short-term disability
❑ Long-term disability
❑ Vision for myself
❑ Vision for my dependent(s)
❑ Life/Add
❑ Dependent Life
❑ Supplemental Life $_____
❑ All coverage offered by plan

DEPENDENT INFORMATION

					CHECK ALL THAT APPLY			
First / Last / Middle	**Birthdate mo/day/yr**	**SS Number**	**Sex**	**Relationship**	**Medical**	**Vision**	**Dental**	**Disabled***

*If child is disable and over age 26, please submit proof of disability.

CHANGES IN COVERAGE STATUS

Indicate desired changes to current coverages below

Basic Life ❑ Employee

Changes in active employee status to ❑ General Employee ❑ Department Head ❑ Top Administrator

Changes from current status to retiree ❑ Employee ❑ Spouse ❑ Child(ren)

Changes from current status to Medicare Supplement* ❑ Employee ❑ Spouse

*Copy of Medicare card required to change status to Medicare Supplement. If retiring with partial benefits, indicate coverages terminated on front of card.

Employee Current Annual Salary _____ Effective Date of Change _____

Department Change ❑ Yes ❑ No If yes, name of new department _____

OTHER CHANGES

Effective date of change _____

❑ Change of address _____ City _____ St ____ Zip _____

❑ Name change from _____ to _____

❑ Location change _____ to _____

❑ Beneficiary change _____ Relationship to insured _____

❑ Other _____

Employee's signature is required for all changes and terminations except termination of employment.

I agree that to the best of my knowledge and belief, all statements and answers to the questions in this application are complete and true and agree that they will be the basis of the issuance of any coverage by any underwriter or carrier. Subject to the approval of this application the benefits applied for shall become effective in accordance with the summary plan description of your employer's health care plan.

Signature of Employee _____ Date _____

TO BE COMPLETED BY EMPLOYER

This must be completed in order to be processed.

I certify the above information to be complete and accurate to the best of my knowledge.

Authorized Signature _____ Date _____

INSTRUCTION

If you have any questions please contact MedCost at 1-800-795-1023

Mail change card immediately with appropriate documentation to:

MedCost Benefit Services
PO Box 24042
Winston-Salem, NC 27114