Health Insurance Change/Cancel Form

Employee Name _____ SS#/Employee ID _____

Qualifying Event _____ Event Date _____ Effective Date for Changes _____

Standard ☐ Basic ☐

DEPENDENT CHANGES

(Employee should notify employer if any dependent's address is different from the employee's address.)

Drop	Add	Name	Gender	Relationship	Date of Birth	Social Security #

I understand, agree, and represent:

- I have read this document or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of the insurance company's other rights and requirements.
- If this change form is accepted, coverage will be effective on the date specified by the insurance company on the certificate of coverage/certificate of insurance. If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within 31 days after the qualifying event.
- If any deductions are required for this coverage, I authorize those deductions from my earnings.
- Any misrepresentation contained herein relied on by the insurance company may be used to reduce or deny a claim(s) or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of health insurance benefits.

Employee Signature _____ Date _____

CANCEL EMPLOYEE COVERAGE:

Reason _____ Effective Date _____

Employee Signature _____ Date _____