USAble Administrators

P.O. Box 1460
Little Rock, Arkansas 72203-1460

CHANGE FORM

EMPLOYEE INFORMATION

EMPLOYEE NAME	EMPLOYER NAME	GROUP #	SOCIAL SECURITY NUMBER
			___-___-____

Are you a current, active employee? ☐ Yes ☐ No If No, retirement date: _____

TYPE OF CHANGE (CHECK APPLICABLE BOX / BOXES)

☐ Change to family plan (Sections I & III)
☐ Change to individual plan (Sections II & IV)
☐ Add spouse / dependents (Section III)
☐ Delete spouse / dependents (Section IV)
☐ Address change (Section V)
☐ Change in Group Number (Section VI)
☐ Name change (Section VII)
☐ PCN physician transfer* (Section VIII)
☐ Termination from PCN* (Section IX)
☐ Termination from standard benefits (Section X)
☐ Other (Section XI)

COMPLETE APPLICABLE SECTIONS

I. Change to family plan:
Date of marriage_____

II. Change to individual plan:
Date of divorce_____
Date of death (SPOUSE/DEPENDENT) _____

III. Add spouse / dependents:
Effective Date _____

IS THIS A LATE ENROLLMENT**
☐ YES ☐ NO

LAST NAME	FIRST NAME	M.I.	DEPENDENT SOCIAL SECURITY NO.	BIRTHDATE MO	BIRTHDATE DAY	BIRTHDATE YR	SEX M/F	RELATIONSHIP TO EMPLOYEE	**FULL-TIME STUDENT	HANDI-CAPPED	SELECTED PCN PHYSICIAN*	FOR EMPLOYER USE ONLY: PREEXISTING CONDITIONS EXCLUSION PERIOD EXPIRATION DATE

**NAME OF ACCREDITED COLLEGE OR UNIVERSITY _____ SEMESTER FOR WHICH STUDENT IS ENROLLED _____ NUMBER OF HOURS ENROLLED PER SEMESTER _____

Spouse's Employer:
Spouse's Date of Birth:

Do you or any member of your family have other health/dental insurance? ☐ Yes ☐ No ☐ Medicare ☐ Blue Cross/Blue Shield
If Medicare, reason for coverage: ☐ Over 65 ☐ Disabled ☐ Kidney Disease Medicare effective date: _____

If yes, please indicate: Policy Holder _____ Policy # _____
Insurance Co. Name _____
Insurance Co. Address _____

Type of Coverage: ☐ **Medical** ☐ Single ☐ Family ☐ **Dental** ☐ Single ☐ Family

IV. Delete spouse / dependents: Effective Date _____

Last Name	First Name	Middle Initial	Relationship To Employee	Last Name	First Name	Middle Initial	Relationship To Employee

V. Address Change:
Street or P.O. Box _____
City _____
State _____
Zip Code _____
County _____

VI. Change in Group Number: Change From Group # _____ Change To Group # _____ Effective date of change _____

VII. Name Change: Change From _____ Change To _____ Effective date of change _____

VIII. PCN Physician Transfer*
Current PCN physician _____ New PCN physician _____
Name of employee or dependent changing PCN physician _____ Effective date of change _____

IX. Termination from PCN (check applicable box)* ☐ Voluntary transfer to standard plan ☐ Involuntary transfer to standard plan ☐ Termination of employment Termination date _____

X. Termination from standard benefits: Termination Date _____

XI. _____

_____ Employee Signature
_____ **Enrollment Date
_____ Employer Signature
_____ Date

*This applies only to PCN enrolled groups.