

CHANGE REQUEST FORM

UHY Advisors

PO Box 875, Oakland, NJ 07436

Social Security No.	Employee's Last Name	First Name	Middle Initial
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The following changes should be made in my group insurance coverage:

CHANGE MY NAME

From _____ Marriage Divorce

To _____ Correction Legal

CHANGE MY COVERAGE

From: Single Family Husband/Wife Parent/Children

To: Single Family Husband/Wife Parent/Children

If adding dependents, complete the following:

Spouse's First Name	Spouse's Social Security No.	
Spouse's Date of Birth	Spouse's Employer (Company Name)	
Spouse's Employer Address	Spouse's Employer Telephone No.	
Spouse's Health Insurance Company	Policy No.	Does Spouse Have Medicare? Yes <input type="checkbox"/> No <input type="checkbox"/>
List those dependents (children) you wish covered under your policy. If more space is needed use reverse side.		
Last Name	First Name	Date of Birth
Last Name	First Name	Date of Birth
Last Name	First Name	Date of Birth

If change is a result of a recent marriage, provide date of marriage _____

If terminating coverage on dependents, provide reason: _____

CHANGE MY ADDRESS

From _____

To _____

OTHER CHANGE - Explain

I hereby declare that all the statements made are, to the best of my knowledge and behalf, true and complete.

Date _____ Employee Signature _____

EMPLOYER USE ONLY

Plan No. _____ Group Name _____

Effective Date _____ Signature _____