L'OREAL TRAVEL RETAIL AMERICAS
HEALTH BENEFIT PLAN
CHANGE APPLICATION

Preferred
BENEFIT ADMINISTRATORS
INCORPORATED
PO BOX 916188, LONGWOOD, FL 32791-6188

Please Print Clearly

COMPANY NAME: L'Oreal Travel Retail Americas **GROUP: 378**

EMPLOYEE NAME: _____ Member ID #: _____

☐ **Address Change:** _____
Street Address City State Zip Code

☐ **Name Change:** _____ **Date of Marriage:** _____
Previous Name

Date of Divorce: _____

INDICATE DESIRED CHANGES BELOW: (Coverage changes will be effective according to the provisions of the Plan)

Change Medical Coverage To:

- ☐ **Employee Only**
- ☐ **Employee & Spouse****
- ☐ **Employee & Child(ren)**
- ☐ **Employee & Family****
- ☐ **Cancel Medical Coverage**

** A Supplemental Application for Spouse Medical Coverage MUST be attached to enroll a spouse in the Plan.

Reason for Medical Coverage Change:

- ☐ **Marriage or divorce (date: _____)**
- ☐ **Birth or adoption of child (date: _____)**
- ☐ **Death of spouse or child (date: _____)**
- ☐ **Loss of medical coverage due to eligibility (date: _____)**
- ☐ **Exhaustion of COBRA benefits (date:_____)**
- ☐ **Other** _____

Change Life Insurance Coverage:

Volume: $_____

Beneficiary: _____

Relationship: _____

DEPENDENT CHANGES

COMPLETE ONLY IF YOU WANT TO ADD / DELETE FAMILY MEMBERS *LIST LEGAL DEPENDENTS ONLY*

Add	Delete	Full Name of Dependent	Date of Birth	Gender	Relationship to Employee	Social Security # (Required)

Any other Group Health Plan coverage or Medicare coverage in force? ___ NO (If No, Skip A. through E.)
___ YES (If Yes, Complete A. Through E.)

A. **Insurance Co. or Health Plan Name: _____Group #: _____**
B. **Insurance Co. Address: _____Eff. Date: _____**
C. **Employer through which above Policy is held (if any): _____**
D. **Name of Policyholder: _____ ___ Single Coverage or ___ Family Coverage**
E. **If Medicare, is it: ___ Medicare Part A ___ Medicare Part B ___ Due to Disability**

Unless otherwise indicated, I hereby request the Group Health Benefits to which I am or may be entitled and authorize required deductions towards the cost, if applicable. I further authorize any physician, medical practitioner, hospital, medical facility, insurance company, government-sponsored health plan or employer having medical information about me or my covered dependents which relates to the diagnosis, treatment, and prognosis of any illness or injury to release this information to Preferred Benefit Administrators, Inc. This authorization shall remain in effect as long as I remain covered by the Plan.

_____
Employee Signature **Date**

FOR ADMINISTRATIVE USE ONLY

Effective Date: _____CIGNA:_____

Eldorado: _____ Rx Notification: _____