Smith Hulsey & Busey
Health Benefit Plan
Change Application

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

COMPANY NAME: Smith Hulsey & Busey Professional Association **GROUP: 385**

EMPLOYEE NAME: _____ MEMBER ID #: _____

☐ **Name Change:** _____
Previous Name

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

INDICATE DESIRED CHANGES BELOW: **(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

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 (Explain)_____ _____

Change Medical Plan To:

- ☐ Gold Plan
- ☐ EPO Plan**
- ☐ High Deductible Health Plan (HDHP)**

**** If enrolling a spouse in the EPO or HDHP Plan a Supplemental Spouse Application is required.**

DEPENDENT CHANGES

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

Add	Delete	Full Name of Dependent	Social Security Number	Date of Birth	Gender	Relationship to Employee

Important Notice:

A Supplemental Spouse Application is REQUIRED if you are enrolling a spouse for coverage through the Plan.

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. Telephone Number: _____ 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: _____ Eldorado:_____
Rx: _____ CIGNA: _____