

K2 Solutions Health Benefit Plan Change Application



PO BOX 916188, LONGWOOD, FL 32791-6188

Please Print Clearly

COMPANY NAME: K2 Solutions, Inc.

GROUP: 386-_____

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:

- ☐ Base Plan
☐ Buy-Up Plan

Change PPO Network:

- ☐ MedCost PPO (For North & South Carolina employees)
☐ First Health PPO (For employees of all other states)

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

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: _____

Rx Notification: _____ Processed By: _____