Lykes Insurance
Health Benefit Plan

Change Application

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

Please Print Clearly

Employer Name: Lykes Insurance, Inc. **Group #:** 448

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 Plan provisions)**

Change Medical Coverage to:
- ☐ **Employee Only**
- ☐ **Employee + Child/Children**
- ☐ **Employee + Spouse**
- ☐ **Employee + Family**
- ☐ **Cancel Coverage**

Change Medical Plan to:
- ☐ **Co-pay Medical Plan**
- ☐ **HSA Medical Plan**

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

Dependent Changes

Complete ONLY If You Want to ADD / DELETE Family Members

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

Is there 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.

For Administrative Use Only
Effective Date: _____ Eldo:_____
Rx: _____ Cigna: _____

_____
Employee Signature **Date**