Westbrook Service Corporation
Health Benefit Plan

Change Application

Preferred
BENEFIT ADMINISTRATORS
I N C O R P O R A T E D

PO BOX 916188. LONGWOOD. FL 32791-6188

Please Print Clearly

Employer Name: Westbrook Service Corporation   **Group #: 449**

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: **Reason For Change:**

☐ **Employee Only**   ☐ **Birth or adoption of child (date: _____)**
☐ **Employee + Child/Children**   ☐ **Marriage or divorce (date: _____)**
☐ **Employee + Spouse****   ☐ **Death of spouse or child (date: _____)**
☐ **Employee + Family****   ☐ **Loss of medical coverage due to eligibility (date: _____)**
☐ **Cancel Coverage**   ☐ **Exhaustion of COBRA benefits (date: _____)**
                                         ☐ **Other _____ (date: _____)**

> ****Your spouse is not eligible for coverage under this Plan if:**
> - Your spouse is *eligible* for medical coverage, or *enrolled* in medical coverage, through his/her own employer's plan; or
> - Your spouse is *eligible* for Medicare, or *enrolled* in Medicare, based on age or disability.

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.

_____
Employee Signature   Date

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