City of Green Cove Springs
Health Benefit Plan

Change Application

PO BOX 916188. LONGWOOD. FL 32791-6188

Please Print Clearly

Employer Name: City of Green Cove Springs **Group #:** 461

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

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: ________)

Change Medical Plan to:

- ☐ Platinum Plan (A)
- ☐ Gold Plan (B)
- ☐ Bronze Plan (C)
- ☐ Bronze Plan (D)

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: ____________ EId:_________

Rx: ________ Cigna: _________

____

Employee Signature **Date**