RED PLAN CHANGE REQUEST FORM

Western Area School Health Benefit Plan

Administered By: **Consociate**

Employer Information

Employer Name	*Location Code*	*Group ID Number*
		C080301

Original must be mailed to Consociate.

Employee Information

Employee Name (last, first, middle initial)	*Social Security Number*

Change of name and/or address

New Name (if applicable)(last, first, middle initial)

New address (street)	*(city)*	*(state)*	*(ZIP)*

Complete for Adding, Canceling or Changing* Coverage

Medical ☐ add ☐ employee ☐ employee+1 ☐ employee+2 ☐ employee+3/more

Deductible: ☐ $1,000 ☐ $2,000 ☐ HDHP $3,000*

☐ change of deductible

☐ $1,000 ☐ $2,000 ☐ HDHP $3,000*

☐ cancel ☐ employee ☐ spouse ☐ child(ren)

PPO ☐ elect ☐ HealthLink

☐ HFN CHC Elite (limited to Peoria, Knox and Tazewell Counties in IL)

Dental ☐ add ☐ employee ☐ employee+1 ☐ employee+2 ☐ employee+3/more

☐ cancel ☐ employee ☐ spouse ☐ child(ren)

Vision ☐ add ☐ employee ☐ employee+1 ☐ employee+2 ☐ employee+3/more

☐ cancel ☐ employee ☐ spouse ☐ child(ren)

Voluntary Life Insurance

☐ add ☐ employee ☐ spouse ☐ child(ren)
(Evidence of insurability may be necessary)

Effective Date

Date of Event

☐ cancel ☐ employee ☐ spouse ☐ child(ren)

☐ Change in Salary

From: To: Effective Date:

☐ Annual Benefit Amount Increase
(applies only to employee and total amount of insurance cannot exceed 5 times salary or above $200,000)

Current Salary $ _____

Amount of Increase ☐ $10,000 ☐ $20,000 ☐ $30,000 Effective Date: _____

Reason for Adding/Changing Coverage or Dependent

***If adding coverage due to a qualifying event, please attach supporting documentation.**

☐ *marriage ☐ *loss of other group coverage ☐ *court order (attach a copy)

☐ *birth/adoption ☐ open enrollment, effective October 1st ☐ other_____

☐ deductible change only, effective January 1st

Effective Date

Date of Event

Other Insurance Information	
Are you or any of your dependents covered by any other group insurance plan? Medical Plan: ☐ yes ☐ no Dental Plan: ☐ yes ☐ no Vision Plan: ☐ yes ☐ no	
If yes, name of policyholder:	Name, address & telephone # where claims are filed:
List Dependents covered by other plan:	Policy or ID Number:
Is patient eligible for Medicare? ☐ yes ☐ no Medicare # _____	If yes, Medicare effective date for Part A _____ Part B _____

* If you are covered by any other insurance, you are not eligible for the $3000 HDHP.

Reason for Canceling Coverage or a Dependent

☐ divorce ☐spouse's group coverage ☐Medicare

☐ max age limit ☐individual insurance

☐ other _____

Effective Date
Date of Event

Complete for Adding or Canceling a Dependent (include last name if different from the employee)

Spouse's name	Birth Date	☐ male ☐ female	Social security number
Name(s) of child(ren)		☐ male ☐ female	
		☐ male ☐ female	
		☐ male ☐ female	
		☐ male ☐ female	

Employee Signature _____ Date _____

Please return the completed form to your Insurance Representative.