Enrollment Change Request
for group members

P.O. Box 91110
Sioux Falls, SD 57109
(605) 328-6800 • 1-800 752-5863
Fax: (605) 328-6812
sanfordhealthplan.com

Employer Name:______________________________ Division Number: ____________________

Employee Name:______________________________ Member ID #: ____________________

Employee Current Address:______________________________ Date of Birth: ____________________

Change Request (All changes must be requested within 31 days of the date of event)

Effective Date of Change*:________/________/________*Coverage will typically begin the first day of the month following the date of event. Coverage will typically end the last day of the month following the date of event.

Involuntary Cancellation Request – COBRA Continuation rights will be offered by Sanford Health Plan *(employee signature not required)*

- ☐ Employment ended. Last day worked: ______________________________
- ☐ Reduction in hours causing the employee to lose benefits
- ☐ Leave of absence causing the employee to lose benefits
- ☐ Lay-off causing the employee to lose benefits
- ☐ Divorce or legal separation. Spouse Name:______________________________ Date of divorce: ____________________
  Address of Spouse: ______________________________
- ☐ Dependent is no longer eligible for coverage (must specify reason): ______________________________
- ☐ Death of covered employee
- ☐ Retirement: Retiree benefits are not available or employee is not eligible.
- ☐ Military Leave/USSERA

Voluntary Cancellation Request – COBRA Continuation rights <u>will not</u> be offered by Sanford Health Plan

- ☐ Reduction in hours allowing employee to voluntarily cancel benefits
- ☐ Leave of absence allowing employee to voluntarily cancel benefits
- ☐ Death of covered dependent: Name:______________________________ Date of Death: ____________________
- ☐ Employee's entitlement to Medicare
- ☐ Voluntary coverage cancellation of dependent or spouse (must specify reason):______________________________
  List all dependents to be removed from policy: ______________________________
- ☐ Voluntary coverage cancellation of Employee and all dependents (must specify reason): ______________________________
- ☐ Eligibility for subsidy on the Marketplace

Other Policy Change Requests

- ☐ Retirement: Employee is eligible for retirement benefits and is to remain on the policy as a retiree.
- ☐ Change in Deductible/Network Choice from:______________________________ to: ______________________________
  Note: Deductibles can <u>only</u> be changed during Open Enrollment or during a separate qualified life event which must be specified.
  Note: Network changes can only be from a Focused Network to a Broad Network. .
- ☐ Name Change from:______________________________ to: ______________________________
- ☐ Change of Address: ______________________________
- ☐ Other Change: ______________________________
- ☐ Addition of Spouse (must specify reason):______________________________
- ☐ Addition of Dependent (must specify reason):______________________________

Last Name	First/M.I.	Address (if different)	Birth Date*	Gender (M/F)	Social Security #	Relation

1. *For South Dakota and Iowa employees only: If child is age of 26 or older, please attach proof of full-time student status.
   School name: ______________________________
2. Will anyone listed above be insured on another health insurance policy besides this one? ☐Yes ☐No If Yes, list:

____

Covered Individuals   Policy Holder   Effective Date   Insurance Company

Employee Signature:______________________________ Date:____________

Employer Signature:______________________________ Date:____________