Enrollment Change Request
for group members

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SANFORD HEALTH PLAN

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/Benefit Package Type from: _____ to: _____
Note: Deductibles can <u>only</u> be changed during Open Enrollment or during a separate qualified life event which must be specified.
☐ 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:_____