DetegoHealth
Discover A Better Plan

Effective Date for Change: _____
(Changes are effective 1st of the month following the Status Change date or per the Summary Plan Document)

Employee/Member Status Change Form

This form is to be filled out by Company HR or Owner, as situation mandates

Employee Name	**Social Security #**
Employer Name	**Location/Division**

Please Make the Following Marked Changes

(Note: Form must be completed in ink or typed, send to MemberServices@detegohealth.com once complete

Generally, once an election is made it cannot be revoked or changed during a plan year. However, the employee may revoke an election and file a new election for the remainder of the plan year if both the revocation and new election are on account of and consistent with a change of family status. Special enrollment is not available if the previous coverage loss resulted from fraudulent activity or because the person did not pay premiums.

1. REASON FOR CHANGE

- ☑ New Employee (Hire Date) and Plan Choice (then go to Section 2)
- ☐ Marriage (Date of Marriage)
- ☐ Legal Separation (Date and Copy of Separation Decree)
- ☐ Divorce (Date and Copy of Divorce Decree)
- ☐ Death (Date of Death)
- ☐ Termination of Employment (Last Day Worked)
- ☐ Spouse Newly Eligible/Ineligible for coverage through their employer (Date)
- ☐ Birth/Newborn (Date of Birth)
- ☐ Adoption (Date of Adoption with Copy of Adoption Decree)
- ☐ Reduction in work hours (Date of Reduction of Hours)
- ☐ Exhaustion of COBRA or State Continuation (Last Day of Coverage)
- ☐ Court Order (Please Attach Copy)
- ☐ Other, Specify (Provide Supporting Documentation if Needed)

2. CHANGE OF COVERAGE

ADD: ☐ Medical ☐ Dental ☐ Vision — *Add for Entire Family?* Yes ◯ No ◯
If no, please indicate dependent/s below

DELETE: ☐ Medical ☐ Dental ☐ Vision — *Delete for Entire Family?* Yes ◯ No ◯
If no, please indicate dependent/s below

☐ Add Dependents Listed Below ☐ Remove Dependents Listed Below

Name	Relationship	Birthdate	SS# (Required)

(*If stepchild, does he/she reside with employee at least six months per year? Yes ◯ No ◯
If application date is more than 31 days after marriage date or birthdate, evidence of insurability may be required, please include completed Health Questionnaire form with your submission.

CHANGE OF NAME

From: _____

To: _____

CHANGE OF ADDRESS

From: _____

To: _____

ACKNOWLEDGEMENT *Office Use Only* Date:_____ By: _____	All requests for Change in Status must be completed within 31 days of the date of Status Change. ***Employee will be responsible for all claims after the requested termination date.*** Please reference the group's Summary Plan Document for details on plan eligibility and requirements. Signature: _____ Date:_____