

MUST BE COMPLETED BY EMPLOYER

Effective Date of Change _____

Group # _____ Division# _____

Change to Group # _____ Division # _____

COBRA Expiration Date: ____/____/____

Change In Premium Charged _____ Yes _____ No

Signature of Employer _____

Company Name: _____

Employee Name: _____

Employee SS#: _____

Address Change: _____ City: _____

State: _____ ZIP: _____ Phone #: _____

Name Change From: _____ To: _____

There (is) (is no longer) other health insurance in force for myself and family members. If yes, Insurance company name _____

TERMINATION OF EMPLOYEE OR DEPENDENT(S)

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX

REASON FOR TERMINATION (MUST BE COMPLETED) EMPLOYEE TERMINATION ____/____/____ DEPENDENT GOT MARRIED ____/____/____

DIVORCE ____/____/____ OVER AGE DEPENDENT ____/____/____ DEATH ____/____/____ OTHER ____/____/____

REINSTATEMENT OF EMPLOYEE OR DEPENDENT(S)

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX

REASON FOR REINSTATEMENT (MUST BE COMPLETED) LOSS OF OTHER COVERAGE ____/____/____ RECALLED FROM LAY-OFF ____/____/____

REHIRED ____/____/____ NOW FULL-TIME STUDENT ____/____/____

ADD DEPENDENT(S)

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX	PRIMARY CARE PHYSICIAN (FIRST & LAST NAME) HMO & POS PLANS ONLY

REASON FOR ADDITION (MUST BE COMPLETED). PLEASE PROVIDE ALL APPLICABLE LEGAL DOCUMENTATION COURT ORDERED ____/____/____

BIRTH ____/____/____ MARRIAGE ____/____/____ ADOPTION / LEGAL CUSTODY ____/____/____ OTHER ____/____/____

CHANGE PCP

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX	PRIMARY CARE PHYSICIAN (FIRST & LAST NAME) HMO & POS PLANS ONLY

REASON FOR CHANGE (MUST BE COMPLETED) I.E.: NEED DOCTOR CLOSER TO HOME; CHILD MOVING TO ADULT PHYSICIAN; DOCTOR JUST JOINED PLAN; DISSATISFIED; WHY?

I hereby apply for amendment of my application. It is mutually agreed as follows: That these changes shall not become effective unless and until accepted by HomeTown and will become effective according to the time frame outlined in the Certificate of Coverage; that this application for change in coverage will become part of my original application and will be subject to the terms of agreement(s) in effect with HomeTown Health Plan/HomeTown Insurance Group, Inc.

Signature of Subscriber _____

Date _____

