

TO BE COMPLETED BY THE EMPLOYER

EFFECTIVE DATE OF CHANGE	DEPARTMENT	GROUP NUMBER
NEW HIRE <input type="checkbox"/> YES <input type="checkbox"/> NO	HIRE TRANSFER DATE	EMPLOYEE CLASS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> SALARIED <input type="checkbox"/> HOURLY <input type="checkbox"/> COBRA

TO BE COMPLETED BY THE EMPLOYEE FOR ALL CHANGES

EMPLOYEE SOCIAL SECURITY #	EMPLOYEE NAME
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED	
ADDRESS NUMBER & STREET	CITY STATE ZIP
HOME PHONE ()	WORK PHONE () EXT.
THE ABOVE INFORMATION INDICATES A CHANGE OF: <input type="checkbox"/> NAME <input type="checkbox"/> ADDRESS <input type="checkbox"/> MARITAL STATUS <input type="checkbox"/> NO CHANGE	
NAME ON THE ORIGINAL APPLICATION: _____	

1. ADDITIONS: THE FOLLOWING ELIGIBLE PERSON(S) SHOULD BE ADDED TO MY SUMMACARE PLAN DUE TO:

MARRIAGE DATE OF MARRIAGE _____ BIRTH OTHER (REASON) _____

If adding a dependent over age 19 and your plan requires proof of full time student status, please attach a copy of their school schedule to this form showing current credit hours to prevent a delay in coverage.

If adding a spouse and/or dependents due to loss of coverage, please attach a copy of the HIPAA Certificate to prevent a delay in coverage.

IF ANY OF THE ABOVE APPLY, PLEASE PROVIDE A COPY OF THE APPROPRIATE DOCUMENTATION (I.E. MARRIAGE CERTIFICATE, BIRTH CERTIFICATE, OR COURT ORDER STATING WHO IS ORDERED BY THE COURTS TO PROVIDE PRINCIPLE SUPPORT AND MEDICAL CARE FOR THE DEPENDENT LISTED, ETC.)

NAME (LAST, FIRST, MI)	RELATIONSHIP	GENDER	DATE OF BIRTH	SOCIAL SECURITY #	PCP#	NEW PATIENT?	
						YES	NO
						YES	NO
						YES	NO

2. DELETIONS: THE FOLLOWING PERSON(S) SHOULD BE DELETED FROM MY SUMMACARE PLAN:

NAME (LAST, FIRST, MI)	RELATIONSHIP	GENDER	DATE OF EVENT	TERMINATION REASON SEE CODES	KEEP AS LIFE INSURANCE ONLY	
					YES	NO
					YES	NO
					YES	NO

DI = Divorce DT = Death TM = Involuntarily terminated from company TV = Voluntarily leaving plan (I.e. = Electing spousal coverage, etc.)
 IF APPLICABLE, IS YOUR SPOUSE EMPLOYED? IF YES, PLEASE GIVE NAME & ADDRESS OF SPOUSE'S EMPLOYER

YES NO NAME ADDRESS

ARE YOU, YOUR SPOUSE OR YOUR DEPENDENTS COVERED BY SOME OTHER TYPE OF HEALTH INSURANCE?

IF "YES", PLEASE COMPLETE THE FOLLOWING INFORMATION: YES NO

INSURANCE COMPANY NAME & ADDRESS	COVERED PERSON/POLICY HOLDER	ID#	GROUP #	TYPE OF COVERAGE
				<input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> OTHER

MEDICARE ELIGIBILITY (Complete this section if you, your spouse or dependents are covered by Medicare Parts A and/or B.)

NAME OF COVERED PERSON	MEDICARE #

EMPLOYEE & SPOUSE (if applicable) MUST SIGN AND DATE THE FOLLOWING CERTIFICATION AND AUTHORIZATION:

I certify that all information supplied on this form is true to the best of my knowledge. I understand that all benefits for myself and my eligible dependents will be provided in accordance with the plan. I am familiar with and agree to abide by the terms and conditions governing membership and receipt of health services in the plan, and agree to provisions as stated on the reverse side of this form.

EMPLOYEE _____ DATE _____ SPOUSE (if applicable) _____ DATE _____