



KELLY & ASSOCIATES INSURANCE GROUP, INC.

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MEMBER TERMINATION/CHANGE FORM (If terminating employment only complete sections 1, 2, & 6)

1 Employee Name _____ Social Security # _____
 Last Name First Name MI
Address _____ **Birth Date** ____/____/____
Employer Name _____ **Effective Date of Change** ____/____/____

2 Member Termination Yes No Qualifying Event/Reason _____

3 Change Information

MEDICAL ONLY		DENTAL ONLY		VISION ONLY		ALL LINES		OTHER Plan _____	
FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
<input type="checkbox"/> Employee Only	<input type="checkbox"/>	<input type="checkbox"/> Employee Only	<input type="checkbox"/>	<input type="checkbox"/> Employee Only	<input type="checkbox"/>	<input type="checkbox"/> Employee Only	<input type="checkbox"/>	<input type="checkbox"/> Employee Only	<input type="checkbox"/>
<input type="checkbox"/> Employee & 1 Child	<input type="checkbox"/>	<input type="checkbox"/> Employee & 1 Child	<input type="checkbox"/>	<input type="checkbox"/> Employee & 1 Child	<input type="checkbox"/>	<input type="checkbox"/> Employee & 1 Child	<input type="checkbox"/>	<input type="checkbox"/> Employee & 1 Child	<input type="checkbox"/>
<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/>	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/>	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/>	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/>	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/>
<input type="checkbox"/> Family	<input type="checkbox"/>	<input type="checkbox"/> Family	<input type="checkbox"/>	<input type="checkbox"/> Family	<input type="checkbox"/>	<input type="checkbox"/> Family	<input type="checkbox"/>	<input type="checkbox"/> Family	<input type="checkbox"/>
<input type="checkbox"/> None	<input type="checkbox"/>	<input type="checkbox"/> None	<input type="checkbox"/>	<input type="checkbox"/> None	<input type="checkbox"/>	<input type="checkbox"/> None	<input type="checkbox"/>	<input type="checkbox"/> None	<input type="checkbox"/>

Dependent Add (Complete section below. If adding spouse, date of marriage ____/____/____)
 Disenroll dependent(s) only- (Complete section below) Reason _____

Last, Full First, M.I.	Social Security #	Birth Date	Sex (M/F)	F/T Student (Y/N)	Disabled (Y/N)	POS or HMO only Primary Care Physician (PCP) name & # OB/GYN Physician name & # (if required)		Existing Patient? (Y/N)
						Physician Name	Physician #	
Emp								
Sp								
Chd								
Chd								
Chd								

Participating Dentist / Provider Code / Dental Office # _____
 Aetna/US Healthcare Pharmacy # _____
 Are you or any of your dependents eligible for Medicare? If Yes: Effective Date (Part A) ____/____/____ Effective Date (Part B) ____/____/____
 Do any of your dependents over 19 attend school on a full-time basis? If Yes: Dependent Name: _____
 Please submit verification of student status (e.g. class schedule, statement from Registrar's office, cancelled check)

4 Member Disenrollment- Ancillary Lines Check as applicable
 Life AD&D Vol. Life Dependent Life Vol. Dependent STD Vol. STD LTD Vol. LTD

5 Name Change From: _____ To: _____
Address Change From: _____ To: _____
Telephone Number Change From: (____) _____ To: (____) _____
Provider Change Circle one (PCP/OBGYN/Dentist)
 From: _____ # _____ To: _____ # _____
Medicare ___ Add ___ Drop Effective Dates _____
 Name _____ Medicare ID # _____ Part A _____ Part B _____
 Name _____ Part A _____ Part B _____
Beneficiary Change- Life Insurance I am changing my group term Life Insurance beneficiary(s) (Please print full name including middle initial)
 To: _____ Relationship _____

6 Member Signature _____ Date ____/____/____
Employer Signature _____ Date ____/____/____

Note: Form invalid without required signatures