KELLY & ASSOCIATES INSURANCE GROUP, INC.

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EXISTING MEMBER TERMINATION / CHANGE FORM

Please print clearly in CAPITAL letters **Please fill in the circles completely**

1 GENERAL INFORMATION

Company Name | KAIG Company ID#

Last Name | First Name | MI | Title (Jr., III, etc.)

Social Security# | Date of Birth (MM-DD-YY) | Employer Phone#

2 EMPLOYEE TERMINATION OF COVERAGE

○ Terminate **ALL** Active Lines of Coverage

○ Health ○ Vision ○ Vol. Life ○ Vol. Sp. Life ○ STD ○ LTD ○ Suppl. Life/AD&D

○ Dental ○ Life/AD&D ○ Vol. AD&D ○ Vol. Dep. Life ○ Vol. STD ○ Vol. LTD

Qualifying Event: ______________ **Qualifying Event Date:** ___/___/___ **Coverage Termination Date:** ___/___/___

3 CHANGE IN CURRENT COVERAGE LEVEL

MEDICAL ONLY			DENTAL ONLY			VISION ONLY			ALL LINES			OTHER Plan ______		
FROM		TO	FROM		TO	FROM		TO	FROM		TO	FROM		TO
○	Employee Only	○	○	Employee Only	○	○	Employee Only	○	○	Employee Only	○	○	Employee Only	○
○	Employee & 1 Child	○	○	Employee & 1 Child	○	○	Employee & 1 Child	○	○	Employee & 1 Child	○	○	Employee & 1 Child	○
○	Employee & Spouse	○	○	Employee & Spouse	○	○	Employee & Spouse	○	○	Employee & Spouse	○	○	Employee & Spouse	○
○	Family	○	○	Family	○	○	Family	○	○	Family	○	○	Family	○

Qualifying Event : ○ Marriage ○ Newborn / Adoption ○ Loss of Coverage **Qualifying Event Date:** ___/___/___ **Requested Date of Change:** ___/___/___

	Last, Full First, M.I.	Social Security #	Birth Date	Sex (M/F)	F/T Student (Y/N)*	Disabled (Y/N)	***POS or HMO only:*** Line 1: PCP Info; Line 2: OB/GYN Info — Physician Name	Physician #	Existing Patient (Y/N)
Sp									
Chd									
Chd									
Chd									

*If full time student, please submit proper form, or appropriate verification of student status (e.g. class schedule, statement from Registrar's office, cancelled check)

Participating Dentist / Provider Code / Dental Office #: Existing Patient: ○ Y ○ N

Are you or any of your dependents eligible for Medicare? If Yes: Effective Date (Part A) ___/___/___ Effective Date (Part B) ___/___/___

4 MISCELLANEOUS CHANGES

Name Change : From: ______________ To: ______________

Address Change: From: ______________ To: ______________

Telephone Number Change: From: (   ) ______________ To: (   ) ______________

Salary Change: From: $ ______ To: $ ______ Effective Date of Change: ___/___/___

Provider Change: ○ PCP ○ OB/GYN ○ DENTIST Change for all members?: ○ Y ○ N If no, list member name: ______________

From: ______________ # ______ To: ______________ # ______ Existing Patient: ○ Y ○ N

Medicare: ○ Add ○ Drop

Name: ______________ Medicare ID #: ______ 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)

Primary To: ______________ Relationship: ______________

Secondary To: ______________ Relationship: ______________

5

EMPLOYEE SIGNATURE ______________ DATE ___/___/___

EMPLOYER SIGNATURE / VERIFICATION ______________ DATE ___/___/___

Note: Form invalid without required signatures

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