

# INDIVIDUAL POLICY CHANGE FORM

## SECTION A: POLICYHOLDER INFORMATION

LEGAL NAME (Last, First, MI):	BIRTHDATE:	AGE:	MEMBER ID OR SOCIAL SECURITY #:
ADDRESS:	CITY:	STATE:	ZIP:

## SECTION B: PLAN DESIGN CHANGE OPTIONS *All requests are subject to approval by Company before becoming effective. Please indicate with 'X' and sign at the bottom.*

PLAN:	DEDUCTIBLE:	DESIGN OPTION:
<input type="checkbox"/> Traditional	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000	Coinsurance: <input type="checkbox"/> 90% <input type="checkbox"/> 70%
<input type="checkbox"/> ValueFirst	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000 <input type="checkbox"/> \$10,000	\$30 Office Visit Copay: <input type="checkbox"/> ADD <input type="checkbox"/> DELETE
<input type="checkbox"/> HDHP	<input type="checkbox"/> \$2500 <input type="checkbox"/> \$3500 <input type="checkbox"/> \$5000 <sup>1</sup>	Coinsurance: <input type="checkbox"/> 100% <input type="checkbox"/> 80%
<small><sup>1</sup>\$5000 deductible available with 100% coinsurance option only.</small>		
<input type="checkbox"/> Economy	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000	Coinsurance: <input type="checkbox"/> 100% <input type="checkbox"/> 80%
<input type="checkbox"/> Other (Please specify): _____		

## SECTION C: POLICY CHANGE OPTIONS *All requests are subject to approval by Company before becoming effective. Please indicate with 'X', complete requested information, and sign at the bottom.*

<p><b>EFFECTIVE DATE OF CHANGE:</b> <input style="width: 100px; height: 20px;" type="text"/></p> <p><input type="checkbox"/> ADD NEWBORN OR ADOPTEE DEPENDENT <i>Please complete Section D</i></p> <p><input type="checkbox"/> ADDRESS CHANGE: Residential address: _____ Mailing address: _____ <i>(If different than above)</i></p> <p><input type="checkbox"/> AGENT OF RECORD CHANGE: Name of new agent: _____</p>	<p><input type="checkbox"/> CONVERT DEPENDENT TO POLICYHOLDER <i>Please complete Section D</i></p> <p><input type="checkbox"/> CONVERT POLICYHOLDER TO DEPENDENT <i>Please complete Section D</i></p> <p><input type="checkbox"/> CONVERT PLAN TYPE TO KIDSFIRST <i>No benefits for parent/guardian</i></p> <p><input type="checkbox"/> MATERNITY CHANGE:   <input type="checkbox"/> ADD BENEFITS -12 month waiting period   <input type="checkbox"/> DELETE BENEFITS</p> <p><input type="checkbox"/> TOBACCO STATUS CHANGE: <i>I certify that in the last 12 months, I have been tobacco free including cigarettes, pipes, cigars, or use of any other form of tobacco.</i></p> <p><input type="checkbox"/> TERMINATE POLICY                      Reason: _____</p> <p><input type="checkbox"/> TERMINATE DEPENDENT(S) <i>Please complete Section D</i></p> <p><input type="checkbox"/> OTHER: _____</p>
<small><i>If a specific effective date is not requested, the requested changes will be effective on the first of the month following receipt of this form</i></small>	

## SECTION D: DEPENDENT INFORMATION *Please print. This section is provided to request changes to dependent coverage. Please indicate reason. Reason Codes:    N=Add Newborn    D=Change Dependent to Policyholder    T=Terminate Coverage*

**A=Add Adoptee                      P=Change Policyholder to Dependent**

REASON CODE	LEGAL NAME (Last, First, MI)	MEMBER ID # or SOCIAL SECURITY #	BIRTHDATE	RELATIONSHIP	AGE	GENDER	TOBACCO USE
						M F	Y N
						M F	Y N
						M F	Y N
						M F	Y N
						M F	Y N

## SECTION E: ADDITIONAL INFORMATION

Please provide any additional information or comments regarding the changes requested:

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## SECTION F: AUTHORIZATION

I have personally completed this form and am requesting the changes indicated. I represent the information to be complete and accurate to the best of my knowledge and belief, and understand that the requests on this form shall not be binding until approved by Cox Health Systems Insurance Company.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_