



## CHANGE REQUEST FORM

First Name	M.I.	Last Name	Social Security No.	Date of Birth
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Home Address \_\_\_\_\_

**Current Coverage Information:** ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

**Change coverage as indicated below:**

Name Change

Current Name: \_\_\_\_\_ New Name: \_\_\_\_\_

Address Change

New Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Terminate a Family Member(s)

Name(s) \_\_\_\_\_

Reason:  Divorce  Death  Legal Separation  Other Date of Event \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(If Spouse is being terminated, Reason and Date of Event must be provided to process request.)

Plan Type — Change to:  Employee Only  Employee/Spouse  Employee/Child(ren)  Employee/Spouse/Child(ren)

Cancel Coverage Date of Cancellation: \_\_\_\_\_

Other \_\_\_\_\_

US Able Life Insurance – Beneficiary Change

I hereby designate the beneficiary or beneficiaries listed below under this certificate and revoke the appointment of any existing beneficiary.

First Name	M.I.	Last Name	Date of Birth	Relationship

**The following changes apply to Health Advantage contracts only:**

Primary Care Physician (PCP) Change

1. Member Name: \_\_\_\_\_ PCP: \_\_\_\_\_ PCP No. \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Clinic Address: \_\_\_\_\_

2. Member Name: \_\_\_\_\_ PCP: \_\_\_\_\_ PCP No. \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Clinic Address: \_\_\_\_\_

3. Member Name: \_\_\_\_\_ PCP: \_\_\_\_\_ PCP No. \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Clinic Address: \_\_\_\_\_

In signing below, I represent that the statements and answers given in this application are true, complete and correctly recorded to the best of my knowledge and belief.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

Signature of Applicant _____	Date _____
Signature of Spouse _____	Date _____
Signature of Group Administrator _____	Date _____