ARBA HEALTH PLAN CHANGE FORM

COMPANY INFORMATION

Company Name: ______________________________

Contact Name: ____________________ Title / Role: ____________________

Phone ____________________ Email: ____________________

Contact Signature ______________________________

EMPLOYEE INFORMATION

Name: ______________________________

Address ______________________________

DOB: ____ - ____ - ____ SSN: ____ - ____ - ____

Employee Signature: ______________________________

Gender: __________ Male __________ Female

REASON FOR BENEFIT CHANGES

You must submit legal documentation of the event along with this form.

Event:

__________ Marriage

__________ Divorce

__________ Birth or Adoption of Child

__________ Dependent Reached 26 Years of Age

__________ Dependent lost or acquired benefits

__________ Other:

Date of Event: ____ / ____ / ____

MEMBERSHIP INFORMATION

Please indicate below the plan(s) in which the subscribers are to be enrolled/removed. The employee's information only needs to be listed if there is to be a change in his/her enrollments.

Name: ______________________________ Relationship to Employee: ______ Spouse ______ Child

Gender: ______ Male ______ Female DOB: ______ / ______ / ______ SSN: ______ - ______ - ______

Please select which plan(s) this person should be enrolled in or removed from:

Medical: ______ Premier Plan ______ Value Plan ______ Decline / Remove Coverage

Dental: ______ Enhanced Plan ______ Basic Plan ______ Decline / Remove Coverage

Vision: ______ Premier Plan ______ Decline / Remove Coverage

Name: ______________________________ Relationship to Employee: ______ Spouse ______ Child

Gender: ______ Male ______ Female DOB: ______ / ______ / ______ SSN: ______ - ______ - ______

Please select which plan(s) this person should be enrolled in or removed from:

Medical: ______ Premier Plan ______ Value Plan ______ Decline / Remove Coverage

Dental: ______ Enhanced Plan ______ Basic Plan ______ Decline / Remove Coverage

Vision: ______ Premier Plan ______ Decline / Remove Coverage

Name: ______________________________ Relationship to Employee: ______ Spouse ______ Child

Gender: ______ Male ______ Female DOB: ______ / ______ / ______ SSN: ______ - ______ - ______

Please select which plan(s) this person should be enrolled in or removed from:

Medical: ______ Premier Plan ______ Value Plan ______ Decline / Remove Coverage

Dental: ______ Enhanced Plan ______ Basic Plan ______ Decline / Remove Coverage

Vision: ______ Premier Plan ______ Decline / Remove Coverage