Group Insurance Service Center, Inc.
PO Box 9120, Marshfield, MA 02050
800-242-4472 Fax: 781-829-8724

EMPLOYEE CHANGE FORM

EMPLOYERS's Name_____ Location_____

Employee's Name_____ Employee SS#_____
First Last

Change Name From_____ To_____
First Last First Last

Change Address To_____ Phone #_____

Coverage AFTER Changes (Check all that apply)		Changes to be Made (Check all that Apply)	ADD	REMOVE	ADD	REMOVE
Individual Medical	Family Medical	Family Members			Medical	
Individual Dental	Family Dental	Life and AD&D			Dental	
Life & AD&D		Remove ALL coverage(s)				

INDIVIDUALS TO BE ADDED / REMOVED

Name	Sex	Date of Birth	Relationship	Reason for Change	Dependent Social Sec #	Eff. Date of Change

If adding coverage is due to loss of coverage (special enrollment event), please answer following questions:
Last day of coverage through other health plan: _____
Reason for loss of coverage: _____
Certificate of prior coverage is attached: Yes No
Note: Coverage for a special enrollment will not take place until satisfactory proof of loss of coverage has been provided.

If adding a spouse, give date of marriage	Date	If child is being added due to adoption, give date of adoption	Date

If divorced or legally separated, give date of final divorce	Date	If child(ren) added due to Court Order, give date & attach copy of Order	Date

Are you or any family members covered by any other medical plans? Yes (if yes, please fill in below) No

Name	Employer	Address	Carrier

CHANGE OF BENEFICIARY

Name of Beneficiary	Relationship to Employee

I understand coverage will be effective when I have met the eligibility rules in the Plan. I agree that a copy of my signature on this form may be used and authorize any deductions required of me for this coverage from my salary. I state that the information I also have furnished above, to the best of my knowledge and belief, is true, correct and complete.

Employee's Signature	Date