



School Insurance Specialists

# GROUP INSURANCE CHANGE FORM REQUEST

SET SEG • 415 W. Kalamazoo • Lansing, Michigan 48933 • 1-800-292-5421

**INSTRUCTIONS:** Please indicate only the change(s) you are reporting at this time. This Change Form Request will facilitate the change(s). A new application is not necessary. The change will not be valid unless this form is signed and dated by the employee.

## FOR SET FRINGE BENEFIT PLANS

### EMPLOYEE INFORMATION:

Name \_\_\_\_\_ Social Security No. \_\_\_\_\_  
LAST FIRST

### SECTION I: GENERAL

a) **NAME CHANGE:** To: \_\_\_\_\_  
LAST FIRST

b) **ADDRESS CHANGE:** To: \_\_\_\_\_  
STREET NAME & NUMBER  
CITY STATE ZIP

c) **MARITAL STATUS CHANGE:**  Married; Date \_\_\_\_\_  Divorced; Date \_\_\_\_\_  Legally Separated; Date \_\_\_\_\_

d) **JOB TITLE OR POSITION CHANGE:** To: \_\_\_\_\_ Date \_\_\_\_\_

e) **CANCELLATION OF EMPLOYER-PROVIDED INSURANCE PLAN** DATE \_\_\_\_\_ **COMPLETE SECTION II BELOW**

### SECTION II: DEPENDENT STATUS CHANGE

Name (first)	Last (if different)	Sex M F	Social Security #	Birthdate MM/DD/YY	Relationship	Add	Delete	Reason* (see below)	Insurance Affected (Medical, Dental, Vision)	Other Insurance Yes No

\*Please insert the corresponding number as it applies to this change: (1) Marriage (2) Divorce (3) Employment (4) Continue Education (5) Death (6) Birth (7) Other (please explain)

If you named a child, above, whose birth parents are divorced or separated, is there a court order stating which parent is responsible for providing health insurance (Please attach a copy of the court order)  Yes — If yes,  Father  Mother  No

Name of Subscriber \_\_\_\_\_ Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

Name of Medical Insurance Co. \_\_\_\_\_ Name of Dental Insurance Co. \_\_\_\_\_ Name of Vision Insurance Co. \_\_\_\_\_

### SECTION III: ELIGIBLE FOR MEDICARE

My dependent, \_\_\_\_\_, is eligible for Medicare Plans A and B, prior to the attainment of age 65.  
FULL NAME

Medicare coverage is effective as of \_\_\_\_\_  
MONTH DAY YEAR

**AUTHORIZATION:** I hereby understand that I am authorizing SET, Inc. to revise my Group Insurance coverage record(s) in accordance with the Change Request Form designation. Further, the effective date of the request(s) will be determined by my eligibility and the underwriting policies of the Union Security Insurance Company, Blue Cross and Blue Shield of Michigan or other insurers as applicable, and any additional contribution required may be deducted from my earnings.

Date \_\_\_\_\_ Signature of Employee \_\_\_\_\_

Name of Employer \_\_\_\_\_

**SET USE ONLY:** Effective Date \_\_\_\_\_ Approved By \_\_\_\_\_ Date \_\_\_\_\_