SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

Large or Small Employer (Existing)

Health Plan Change Request

Employer name _____

Parent group number _____ Effective date of change_____

Complete any change(s) that apply and sign below.

Demographic change:

Employer name _____

Employer contact _____ Employer email _____

Physical address (PO Box not accepted): Street _____

City _____ State _____ ZIP _____ County _____

Mailing address: ☐ Mailing address is the same as physical address

Street _____ City _____ State _____ ZIP _____ County _____

Billing address: ☐ Billing address is the same as physical address ☐ Billing address is the same as mailing address

Street _____ City _____ State _____ ZIP _____ County _____

Billing contact _____ Phone number _____

Email address _____

Add domestic partner coverage *(see criteria on amendment)*:

Type of coverage: ☐ Same gender and opposite gender ☐ Same gender only

Eligible dependent children of domestic partner: ☐ Yes ☐ No

Employer can change a waiting period once per benefit year. Changes can be made at the renewal or off renewal. Changes off renewal must be communicated by the employer to the employees 60 days prior to the effective date of the change per Section 102 of the Employee Retirement Income Security Act of 1974 (ERISA).

Waiting period change:

☐ Immediately ☐ First of the month following date of hire ☐ 30 days ☐ First of the month following 30 days
☐ 60 days ☐ First of the month following 60 days ☐ 90 days

Recall period change:

☐ Following original waiting period ☐ First of the month following return to work ☐ Immediately following return to work

Requested termination of coverage:

☐ End of month in which employment terminates ☐ End of day that employment terminates

Employer premium contribution change:

What **percentage** of the monthly premium is to be paid by the employer for each of the following coverages **(each must be at least 25%)**: Single _____ Employee and spouse _____ Employee and children _____ Full family _____

_____ _____ _____ /_____ /_____
Employer representative signature Position/Title Date (month/day/year)

Security Health Plan (Internal Use Only)	
Effective date (month/day/year)	Approval signature _____ Date _____ /_____ /_____

Return this form via email to your account manager or fax to 715-221-9456.