SecurityHealth Plan℠

Promises kept, plain and simple.®

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Large or Small Employer (Existing)

Subscriber Health Plan Change Request

Note: Some changes may affect your premium.

Employer name				Effective date (m/d/y)
Subscriber last name	First name	MI	Subscriber number	

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced/Separated

☐ Open Enrollment Period (OEP) ☐ Special Enrollment Period (SEP) SEP reason

Check and complete changes that apply and sign below.

☐ **Name change**	Change from	Change to	Reason for change	
	If married, spouse's name	Date of marriage (m/d/y) / /	Date of divorce (m/d/y) *If applicable* / /	
☐ **Phone number change**	Change to ( ) ☐ Home ☐ Work ☐ Cell			
☐ **Email address change**	Change to			
☐ **Address change** Change applies to: ☐ Residence address ☐ Mailing address	Street/Route			Apartment number
	City	State	ZIP code	County
☐ **Primary care provider**	Name (first and last)	Facility/Clinic location where primary care is received		
☐ **Plan change**	Group number	Sub-group/location	Plan description	
☐ **Cancel policy** ☐ Move to COBRA	Last date of employment (m/d/y) / /	☐ Individual and family ☐ Employer group	Cancel reason	
☐ **Correction/Addition**	First name	MI	Last name	
	☐ DOB ☐ SSN ☐ Gender ☐ Date of hire	New information		
	☐ Reinstate policy Reason _____			

☐ **Addition of spouse or dependent(s)**

Name				Gender		Date of Birth			Relationship to Subscriber	Social Security Number
Last	Former Last/Maiden	First	MI	M	F	Mo	Day	Yr		
				☐	☐					
Primary care provider name (first and last)				Facility/Clinic location where primary care is received						
				☐	☐					
Primary care provider name (first and last)				Facility/Clinic location where primary care is received						

Date added (m/d/y) ____ /____ /____ Reason added _____

☐ **Deletion of dependent(s)**

Name			Date of Birth			Termination Date
Last	First	MI	Mo	Day	Yr	

Reason deleted _____

Subscriber or employer representative signature _____ Date (m/d/y) _____ /_____ /_____
(Signature required for any change)

Please return form via email at shpmember@securityhealth.org or fax to 715-221-9974.