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)

Employer 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 _____

Contact: ☐ Primary ☐ Billing _____ Access to online and billing reports: ☐ Yes ☐ No

Email _____ Phone _____

Physical address (PO Box not accepted): Street _____

City _____ State _____ ZIP _____ County _____

This address is also used for: ☐ Mailing ☐ Billing

If mailing and/or billing is different, indicate below

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

Changing from part-time to full-time: ☐ Yes ☐ No If no, explain eligibility guidelines: _____

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:

Provide your contribution for each of the following coverages.

Each must be at least 25%:

Employee _____ Employee & Spouse _____ Employee & Child(ren) _____ Family _____

NOTE: Security Health Plan's requirement for employee contribution must equal 25% of the employee only premium and, on average, 25% of the other three types of coverage. This could vary based on your plan options and rate structures.

_____ _____ _____ /_____ /_____
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.