SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000

1-800-472-3450, option 2
715-221-9444, option 2
TTY 711
Fax: 715-221-9974

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 ☐ Domestic partner

☐ Open Enrollment Period (OEP)

☐ Special Enrollment Period (SEP) *(documentation, qualifying event and event date required)*

Date of event (m/d/y) _____ /_____ /_____ ☐ Birth/adoption ☐ Marriage ☐ Permanent move ☐ Loss of coverage

If you are enrolling due to loss of coverage, submit proof of loss to your employer.

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/email change

Phone change to	Email change to

☐ Address change

Change applies to: ☐ Physical address ☐ Mailing address

Street	Apartment number

City	State	ZIP code	County

☐ Plan change

Group number	Subgroup/location	Plan description Deductible amount _____ Network _____

☐ Cancel policy

Last date of employment (m/d/y) / /	Cancel reason

☐ Move to COBRA

Effective date (m/d/y) / /

☐ Correction/addition

First name	MI	Last name

☐ DOB ☐ SSN ☐ Sex assigned at birth ☐ Date of hire — New information

☐ Reinstate policy Reason _____

☐ Addition of spouse or dependent(s)

Name				Sex assigned at birth		Date of birth			Relationship to subscriber	Social security number
Last	Former last/maiden	First	MI	M	F	Mo	Day	Yr		

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

☐ Deletion of dependent(s)

Name			Date of birth			Termination date		
Last	First	MI	Mo	Day	Yr	Mo	Day	Yr

Reason deleted _____

I attest that the above answers are true and complete to the best of my knowledge. I acknowledge that Security Health Plan may request proof of documentation related to enrollment eligibility of any member/employee, and I agree to cooperate in providing such documentation upon request.

Subscriber or employer representative signature _____ Date (m/d/y) _____ /_____ /_____

(Signature required for any change)

Title of employer representative (Required if signed by employer representative) _____

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

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Limited English Proficiency Language Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-472-2363 (TTY 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-472-2363 (TTY 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-472-2363 (TTY 711).

If you require materials in large print, call 1-800-472-2363 (TTY 711).

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