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

Existing Large or Small Business

Employer Health Plan Change Request

Group name _____

Parent group number _____

Effective date of change _____

Check and complete any change(s) that apply and sign below.

☐ Demographic change:

Group name _____

Group contact _____

Physical address _____ City _____ State _____ ZIP _____ County _____

☐ Mailing address is the same as physical address

Mailing address _____ City _____ State _____ ZIP _____ County _____

Billing contact _____ Phone number _____

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

Billing address _____ City _____ State _____ ZIP _____ County _____

☐ Probationary period change (cannot exceed 90 days):

A. Requested probationary period:

☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other _____

B. Effective date following probationary period:

☐ First of month following probationary period, if any

☐ Immediately following probationary period, if any (cannot exceed 90 days)

☐ Recall period change:

☐ Follow probationary period

☐ First of 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: Single _____ percent Family _____ percent

_____ _____ /_____ /_____
Group representative signature Date (month/day/year)

_____
Position/Title

Security Health Plan – Internal Use Only

Effective date (month/day/year) _____ /_____ /_____

Approval signature _____ Date _____ /_____ /_____

