**NORTH AMERICAN DIVISION BENEFITS**
# Health Care

# HEALTH CARE EMPLOYEE BENEFITS
# CHANGE REQUEST FORM

## EMPLOYEE INSTRUCTIONS:
This form is to be completed only when a change needs to be made for an existing employee. Do not complete this form to add a new employee; an enrollment application must be completed for this purpose. This form may be completed by the employee, but must be signed by the employer before it is sent to Adventist Risk Management®, Inc. - Health Benefits Services.

## EMPLOYEE INFORMATION:

NAME:                  SSN#

**CHANGES TO BE MADE:** *Mark Choice*    Name      Address      Phone Number      Add Spouse      Add Children

**CHANGE DETAILS:** (Fill in details for above marked choice)

### EMPLOYEE INFORMATION

| | | | |
|---|---|---|---|
| **NEW NAME** LAST NAME: | FIRST NAME: | MIDDLE INITIAL: | NEW PHONE# |
| **NEW ADDRESS** STREET: | CITY | STATE: | ZIP CODE: |

### SPOUSE INFORMATION

LAST NAME:      FIRST NAME:      MIDDLE INITIAL:      DATE OF BIRTH:      SSN#

EMPLOYER NAME:

**EMPLOYER ADDRESS** STREET:      CITY      STATE:      ZIP CODE:

OTHER INSURANCE:    YES    NO      THIS OTHER INSURANCE IS:    PRIMARY    SECONDARY

COMPANY:                EFFECTIVE DATE: (MM/DD/YYYY)

ADDRESS:      CITY      STATE:      ZIP CODE:

### CHILDREN INFORMATION

| FIRST NAME | M.I. | LAST NAME | BIRTHDATE (MM/DD/YYYY) | Sex | DEPENDANT'S SSN# | OTHER INSURANCE YES/NO | PRIMARY / SECONDARY |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

OTHER INSURANCE NAME:      PHONE#:      EFFECTIVE DATE: (MM/DD/YYYY)

EMPLOYEE SIGNATURE:      DATE SIGNED: (MM/DD/YYYY)

This form can be submitted electronically to: **HEALTHCAREELIGIBILITY@adventistrisk.org**
(You **must** save the document to your computer then attach it to the e-mail generated by the link above)

## AUTHORIZED EMPLOYER'S SIGNATURE REQUIRED

| EMPLOYER NAME | EFFECTIVE DATE (MM/DD/YYYY) | GROUP # | SUBGROUP # |
|---|---|---|---|
| | | | |

| RECEIVED ON: | | | | |
|---|---|---|---|---|
| IBC | | | | |
| TRANS# | | | | |
| CARD | IBC | | | |
| CARD | ARM | | | |
| VERIFIED | IBC | WEB | UCD | RX |
| HIPPA CERT | | | | |
| **FOR ARM OFFICE USE ONLY** | | | | |

EMPLOYER SIGNATURE*:      DATE (MM/DD/YYYY):

SIGNATORY'S NAME:      COVERAGE CODE:

SIGNATORY'S TITLE:

**\*Please enter your initials to serve as your digital signature.**
By entering your initials and sending this form attached to an e-mail from your e-mail account, we will consider this form signed by you.