

NORTH AMERICA ADMINISTRATORS, L.P. CHANGE FORM

Employee Name: Last First Middle Initial			Social Security Number		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (Mo./Day/Yr.)		Employer _____
Email Address							HIRE DATE: _____	
Addition of Dependent Coverage: <input type="checkbox"/> Spouse Child(ren): <input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild			Date of Marriage / /		Marital Status:		Change To:	
Termination of ALL Dependent Coverage <input type="checkbox"/>			Effective Date / /		<input type="checkbox"/> Single		<input type="checkbox"/> Self	
Termination of Dependents <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)			Effective Date / /		<input type="checkbox"/> Married		<input type="checkbox"/> Self & Spouse	
Names: _____					<input type="checkbox"/> Divorced		<input type="checkbox"/> Self & Children	
Reason: _____					<input type="checkbox"/> Widowed		<input type="checkbox"/> Self & Family	
Change: <input type="checkbox"/> Class			From: To:		<input type="checkbox"/> Legally Separated		Coverage Elections <input type="checkbox"/> Standard Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> Dependent Life <input type="checkbox"/> Supplemental Life <input type="checkbox"/> Disability Income <input type="checkbox"/> LTD	
			Effective Date / /		CHANGE OF ADDRESS			
			Effective Date / /		Name _____			
<input type="checkbox"/> Location			Effective Date / /		Address _____			
			Effective Date / /		City _____ State _____ Zip _____ County _____			
			Effective Date / /		OTHER INSURANCE INFORMATION			
Life Insurance Incr./Decr.			From: To:		If you or any of your dependents are covered by other insurance, you must fill out the following information to qualify at any time as a Special Enrollee (attach separate sheet if additional space is required).			
			Effective Date / /		Name of Person covered by other Insurance			Social Security Number
Suppl. Life Ins. Incr./Decr.			From: To:		Name of other Employer			Group No.
			Effective Date / /		Name of other Insurance Company			
Reinstate Insurance			Prior Effective Date of Termination		Address of other Insurance Company			
Cancel ALL Coverage <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Leave/Lay Off			Effective Date / /					

CHANGE OF BENEFICIARY:	Last	First	Middle Initial	Relationship
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Use this space to list all eligible dependents you wish to cover. Last name required if different from employee's.

Spouse's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Relationship <input type="checkbox"/> Natural Child <input type="checkbox"/> Stepchild Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Relationship <input type="checkbox"/> Natural Child <input type="checkbox"/> Stepchild Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Relationship <input type="checkbox"/> Natural Child <input type="checkbox"/> Stepchild Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Relationship <input type="checkbox"/> Natural Child <input type="checkbox"/> Stepchild Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Relationship <input type="checkbox"/> Natural Child <input type="checkbox"/> Stepchild Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Relationship <input type="checkbox"/> Natural Child <input type="checkbox"/> Stepchild Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No

I certify that the above information is true and correct. I hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to furnish North America Administrators, L.P. with full information regarding medical treatment (including copies of their records). I also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish to North America Administrators, L.P. with information regarding benefits to which I may be entitled. A copy or photocopy of this authorization shall be considered as effective and valid as the original.

EMPLOYEE SIGNATURE _____ DATE _____