NORTH AMERICA ADMINISTRATORS, L.P. CHANGE FORM

naa North America Administrators

Employee Name: Last	First	Middle Initial	Social Security Number	Sex ☐ M ☐ F	Date of Birth (Mo./Day/Yr.)

Employer____________________________

HIRE DATE: __________________________

EFFECTIVE DATE OF CHANGE: ________________

REMARKS ____________________________

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Email Address

Addition of Dependent Coverage: ☐ Spouse Child(ren): ☐ Natural ☐ Adopted ☐ Stepchild	Date of Marriage / /
Termination of ***ALL*** Dependent Coverage ☐	Effective Date / /
Termination of Dependents ☐ Spouse ☐ Child(ren) Names: ________________ ________________ Reason: ________________________	Effective Date / /

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Legally Separated

Change To:
- ☐ Self
- ☐ Self & Spouse
- ☐ Self & Children
- ☐ Self & Family

Coverage Elections
- ☐ Standard Medical
- ☐ Dental
- ☐ Vision
- ☐ Life
- ☐ Dependent Life
- ☐ Supplemental Life
- ☐ Disability Income
- ☐ LTD

Change:	From:	To:	Effective Date
☐ Class __________			/ /
__________ __________			Effective Date / /
☐ Location __________			Effective Date / /
__________ __________			Effective Date / /
Life Insurance Incr./Decr.	From:	To:	Effective Date / /
Suppl. Life Ins. Incr./Decr.	From:	To:	Effective Date / /
Reinstate Insurance	Prior Effective Date of Termination		Effective Date / /
Cancel ALL Coverage ☐ Termination of Employment ☐ Leave/Lay Off			Effective Date / /

CHANGE OF ADDRESS

Name ____

Address_______________________________________

City________________ State ______ Zip_________ County _________

OTHER INSURANCE INFORMATION

If you or any of your dependents are covered by other insurance, you must fill out the following information to quality at any time as a Special Enrollee (attach separate sheet if additional space is required).

Name of Person covered by other Insurance	Social Security Number
Name of other Employer	Group No.
Name of other Insurance Company	
Address of other Insurance Company	

CHANGE OF BENEFICIARY: Last	First	Middle Initial	Relationship	

Use this space to list all eligible dependents you wish to cover. Last name required if different from employee's.

Name	Date of Birth (Mo./Day/Yr.)	Sex	Social Security Number	Relationship
Spouse's Name	Date of Birth (Mo./Day/Yr.)	Sex ☐ M ☐ F	Social Security Number	
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ☐ M ☐ F	Social Security Number	Relationship ☐ Natural Child ☐ Stepchild ☐ Other
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ☐ M ☐ F	Social Security Number	Relationship ☐ Natural Child ☐ Stepchild ☐ Other
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ☐ M ☐ F	Social Security Number	Relationship ☐ Natural Child ☐ Stepchild ☐ Other
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ☐ M ☐ F	Social Security Number	Relationship ☐ Natural Child ☐ Stepchild ☐ Other
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ☐ M ☐ F	Social Security Number	Relationship ☐ Natural Child ☐ Stepchild ☐ Other
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ☐ M ☐ F	Social Security Number	Relationship ☐ Natural Child ☐ Stepchild ☐ Other

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_____________