NORTH AMERICA ADMINISTRATORS, L.P. CHANGE FORM

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 ____________________________

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: ☐ Class	From:	To:	Effective Date / /
			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.

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	Full Time Student ☐ Yes ☐ No
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ☐ M ☐ F	Social Security Number	Relationship ☐ Natural Child ☐ Stepchild	Full Time Student ☐ Yes ☐ No
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ☐ M ☐ F	Social Security Number	Relationship ☐ Natural Child ☐ Stepchild	Full Time Student ☐ Yes ☐ No
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ☐ M ☐ F	Social Security Number	Relationship ☐ Natural Child ☐ Stepchild	Full Time Student ☐ Yes ☐ No
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ☐ M ☐ F	Social Security Number	Relationship ☐ Natural Child ☐ Stepchild	Full Time Student ☐ Yes ☐ No
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex ☐ M ☐ F	Social Security Number	Relationship ☐ Natural Child ☐ Stepchild	Full Time Student ☐ Yes ☐ 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____________