point

CHANGE IN COVERAGE FORM

RETURN FORM TO:
eligibilitym1@pointchealth.com
or Fax: 402-573-8058

EMPLOYER:_____

EMPLOYEE NAME: _____ ID # : _____

EMPLOYEE EMAIL ADDRESS AND MOBILE PHONE NUMBER: _____

☐ **LATE / OPEN**
☐ **SPECIAL ENROLLMENT** **REASON:** _____

Effective Date: _____ Qualifying Event date: _____

☐ **ADD SPOUSE:**
Coverage Desired: ☐ **Medical/Rx** ☐ **Dental** ☐ **Vision** ☐ **Life/AD&D** ☐ **Dep Life** ☐ **STD** ☐ **LTD**

NAME: _____ GENDER: ☐ M ☐ F

SOCIAL SECURITY # : _____

DATE OF BIRTH: _____ MARRIAGE DATE: _____

☐ **ADD CHILD(REN) DUE TO:** ☐ MARRIAGE ☐ BIRTH ☐ ADOPTION ☐ COURT ORDER
Coverage Desired: ☐ **Medical/Rx** ☐ **Dental** ☐ **Vision** ☐ **Life/AD&D** ☐ **Dep Life** ☐ **STD** ☐ **LTD**

1.) NAME: _____ GENDER: ☐ M ☐ F
SOCIAL SECURITY # : _____ DATE OF BIRTH: _____

2.) NAME: _____ GENDER: ☐ M ☐ F
SOCIAL SECURITY # : _____ DATE OF BIRTH: _____

3.) NAME: _____ GENDER: ☐ M ☐ F
SOCIAL SECURITY # : _____ DATE OF BIRTH: _____

☐ **NAME CHANGE:**
Former Name: _____
New Name: _____
Reason for Name Change: _____

☐ **ADDRESS CHANGE**
New Street, City, State, Zip Code
_____
_____
Effective Date: _____

☐ **CHANGE OF BENEFICIARY:**
I hereby revoke any other beneficiary designation and optional method of settlement election and, in accordance with the terms and provisions of the group, designate the person(s) named as beneficiary.
FULL NAME: _____ RELATIONSHIP:_____ BIRTHDATE:_____ PERCENTAGE:_____
FULL NAME: _____ RELATIONSHIP:_____ BIRTHDATE:_____ PERCENTAGE:_____

YOUR APPROVAL
I hereby request my employer to arrange for benefits which I have elected. I authorize my employer to make the proper deductions (if any) from my earnings as my contribution toward the cost of this Plan. I verify that all the information on this form is correct.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

EMPLOYER SIGNATURE: _____ **DATE:** _____