Employee Benefits Change Request Form

addition/termination/change

MED PLAN HERO

For Questions filling out this form call Paula Walstra (219) 869-1293

A. Employee/Employer Information

Employee Name: _____
First *Middle Initial* *Last*

Employer Company Name: _____

B. Transaction	Effective Date	Required Information
☐ Eligible Employee Enrollment *Complete All of Section C & Health Survey*	/ /	**WHO:** ☐ Employee ☐ Spouse ☐ Dependent(S)
☐ Enrolled Employee Termination *Do Not Have To Complete Section C*	/ /	Employee (DOB: ____ /____ /_____) ☐ Medical ☐ All Benefits
☐ Enrolled Employee Change *Complete All Of Section C*	/ /	**WHO:** ☐ Employee ☐ Spouse ☐ Dependent(S)

C. Additional Info

EMPLOYEE:

First Name, Mi: _____ Last Name: _____ Date of Birth: (MM/DD/YYYY) _____
Gender: ○ Male ○ Female Street Address: APT/STE: _____
City: _____ State Abbreviation: _____
ZIP Code: _____ Social Security Number: _____
Phone Number: _____ Email Address: _____
Have Coverage Elsewhere? ○ Yes ○ No Plan: ○ Medical ○ Dental ○ Vision ○ HMRA

SPOUSE:

First Name, Mi: _____ Last Name: _____ Date of Birth: (MM/DD/YYYY) _____
Gender: ○ Male ○ Female Street Address: APT/STE: _____
City: _____ State Abbreviation: _____
ZIP Code: _____ Social Security Number: _____
Phone Number: _____ Plan: ○ Medical ○ Dental ○ Vision ○ HMRA

DEPENDENT:

First Name, Mi: _____ Last Name: _____ Date of Birth: (MM/DD/YYYY) _____
Gender: ○ Male ○ Female Street Address: APT/STE: _____
City: _____ State Abbreviation: _____
ZIP Code: _____ Social Security Number: _____
Phone Number: _____ Plan: ○ Medical ○ Dental ○ Vision ○ HMRA

DEPENDENT:

First Name, Mi: _____ Last Name: _____ Date of Birth: (MM/DD/YYYY) _____
Gender: ○ Male ○ Female Street Address: APT/STE: _____
City: _____ State Abbreviation: _____
ZIP Code: _____ Social Security Number: _____
Phone Number: _____ Plan: ○ Medical ○ Dental ○ Vision ○ HMRA

DEPENDENT:

First Name, Mi: _____ Last Name: _____ Date of Birth: (MM/DD/YYYY) _____

Gender: ○ Male ○ Female Street Address: APT/STE: _____

City: _____ State Abbreviation: _____

ZIP Code: _____ Social Security Number: _____

Phone Number: _____ Plan: ○ Medical ○ Dental ○ Vision ○ HMRA

By signing below, I certify the above is complete and correct. Failure to complete and sign this form will prevent your request.

Employee Signature: _____ Date: _____

Employer Representative Signature: _____ Date: _____

Submit Completed Forms to Paula Walstra
paula@medplanhero.com