



**WARNING:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.

# CHANGE REQUEST FORM

**FOR OFFICE USE ONLY** CHANGE EFFECTIVE: \_\_\_\_\_ EXCLUSIONS: \_\_\_\_\_  
 DATE PROCESSED: \_\_\_\_\_ ISSUED: \_\_\_\_\_

**PLEASE READ CAREFULLY AND COMPLETE IN INK TO PREVENT YOUR COVERAGE FROM BEING DELAYED.**

1

Employer Mt. Vernon Nazarene University Employee \_\_\_\_\_  
 Group/Acct#: 10114 Social Security Number \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Add Spouse

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Date of Marriage \_\_\_\_\_ Spouse employed  Yes  No Spouse's S.S. No. \_\_\_\_\_  
 Employed By \_\_\_\_\_  
Company Name City, State of Employment  
 Is your spouse covered or insured under any other medical coverage (including Medicare and other government plans)?  
 Yes  No If yes, indicate who the carrier is: \_\_\_\_\_  
 Coverage Election  Medical/Rx  Dental  Vision Plus

Add Children

Full Name	Medical/Rx	Dental	Vision Plus	Sex M/F	DOB	Nat ural Chil d	Adopt Child*	Step-Child	Legal Guard.	You &/or your Spouse provide over 50% of Support?	Full-Time Student ? (Y/N)	Credit Hours *

\*Please attach to this application copies of the court orders or legal documents creating this relationship.  
 \*\*If dependent is 19 or older, list the name of the dependent and the educational institution such child is currently attending: \_\_\_\_\_

Spouse employed  Yes  No Employed By \_\_\_\_\_ Date of Marriage \_\_\_\_\_  
 Are children covered or insured under any other medical coverage (including Medicare and other government plans)?  
 Yes  No If yes, indicate who is covered under this other coverage, and who the carrier is: \_\_\_\_\_

Are any of the other Dependents listed above in the legal custody of another Person?  Yes  No If yes, please submit documents.

**CHANGE MARITAL STATUS** From  Single  Divorced  Separated To  Married  Divorced  
 Married  Widowed  Separated  Widowed

**NAME CHANGE**  Employee Name  Dependent's Name \_\_\_\_\_  
(Dependent's former name)  
 Change Name to \_\_\_\_\_

**CHANGE ADDRESS** New Address \_\_\_\_\_

COVERAGE ELECTION	COVERAGE ELECTION	Employee	Employee plus 1	Family
	Medical/Basic Dental			
Medical /Dental Buy Up				
Dental Only				
VISION PLUS ELECTION	VISION PLUS ELECTION			
	Vision Plus			

**DELETE COVERAGE**  Delete Spouse Name \_\_\_\_\_ As of \_\_\_\_\_  
 Delete Child(ren) Name \_\_\_\_\_ As of \_\_\_\_\_  
 Employee Name \_\_\_\_\_ As of \_\_\_\_\_

**TYPE OF COVERAGE TO BE DELETED**  Delete All Coverage As of (indicate last day of work) \_\_\_\_\_  
 Delete Dental As of \_\_\_\_\_  
 Delete Medical Coverage As of \_\_\_\_\_  
 Delete VisPlus Coverage As of \_\_\_\_\_

**NOTICE REGARDING PRIOR HEALTH COVERAGE**

2

If any person for whom application for coverage has been made above was covered under other health coverage within 62 days (not including any waiting period under this plan or any other plan) of the date such person's coverage would become effective under this plan, he or she may be entitled to credit towards any pre-existing conditions restriction under this plan for any coverage time under one or more prior plans. In order to claim this credit, a certificate of creditable coverage from the prior plan(s), or other evidence documenting the person's prior coverage, should be attached to this form.

If coverage was lost under the prior health plan within 30 days of the date of this application, list reason the coverage was terminated under the prior plan. \_\_\_\_\_

**WAIVER OF COVERAGE**

3

If you are declining enrollment for yourself or your dependents (including your spouse) because you have other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within the time period required by your plan (30 or 31 days - see plan document) after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your dependents, provided that you request enrollment within the time limit allowed by your plan after the date of the marriage, birth, adoption, or placement for adoption. Your plan may also allow additional enrollment periods as specified in the plan document. This plan will also allow enrollments as necessary to comply with the terms of medical child support orders, or qualified medical child support orders, as defined in applicable state or federal law. Other than as described, if you fail to enroll at this time you may not be eligible to enroll thereafter, or may be subject to certain restrictions which are described in your plan.

I waive coverage for:  All Medical  All Dental  All Vision Plus  
 Spouse Medical  Spouse Dental  Spouse Vision Plus  
 Child(ren) Medical  Child(ren) Dental  Child(ren) Vision Plus

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Are you waiving the coverage listed above because you and/or your dependents have other health coverage?  Yes  No With whom? \_\_\_\_\_

**Read this Statement and Authorization Carefully**

I hereby request health care coverage and/or insurance and authorize that any requested contribution for the coverage and/or insurance to which I may be entitled be deducted from my earnings. I am employed by the employer shown and am working at least the number of hours per week required by my Employer and shown on the Employer Application. I further understand that any failure to comply with the Utilization Review or Second Surgical Opinion procedures may result in a reduction of benefits. I authorize (1) any physician, hospital, or other health practitioner or facility, (2) any insurance company or health care plan, (3) any state or federal agency providing health care benefits; and (4) any employer to provide MedBen or its legal representative any information in its possession which is relevant to this application for coverage and/or insurance regarding myself or my listed Dependent(s). This information will be used to determine the eligibility for coverage and/or benefits for myself and my listed Dependent(s) and will be utilized by employees, agents and business associates of MedBen with responsibility for (1) reviewing applications and determining eligibility for coverage and/or insurance, (2) process and/or payment of claims, and (3) any health care operations. I hereby authorize and release any provider of health care services, claim administrators, insurers, reinsurers, pharmacy benefit managers or consultants, stop loss carriers, disease management service and/or wellness benefit providers or consultants, and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, health plan service or any other health care operation, to supply each other with information about the health status of, and health care services provided to, me and my listed Dependent(s). This authorization is effective on the date signed and shall remain in effect until the date such coverage and/or insurance is terminated. (You, or any individual authorized by law to act on your behalf, have a right to receive a copy of this authorization). A photographic copy of this authorization shall be as valid as the original. I understand that if I fail to provide this authorization, MedBen will be unable to process my application for coverage and/or insurance. I further understand that I have the right to revoke this authorization by submitting such revocation to the Chief Privacy Officer at MedBen at the address listed on this application. Such revocation will not be effective to the extent that action has been taken in reliance upon this authorization prior to receipt of my revocation or to the extent that my coverage or a claim may be contested under applicable law. I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief. I have legal proof which I can furnish upon request of my relationship to any person listed as a Dependent(s) above. I understand any misstatements or failure to report may be used as a basis for rescission or cancellation of the coverage and/or insurance for me and my Dependent(s), if any.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

I understand that if, upon receipt, the signature is more than 60 days old, a new application will be requested.