

NORTH AMERICA ADMINISTRATORS, L.P. CHANGE FORM

Employee Name: Last	First	Middle Initial	Social Security Number	Date of Birth (Mo./Day/Yr.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Employer
Email Address				HIRE DATE:		

Addition of Dependent Coverage: <input type="checkbox"/> Spouse <input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild	Date of Marriage / /	Termination of ALL Dependent Coverage <input type="checkbox"/>	Termination of Dependents <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	Reason: _____	REMARKS
Names: _____		Termination of Dependents <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)		Termination of Dependents <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	
Change: <input type="checkbox"/> Class		From: _____ To: _____		Termination of Dependents <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	
Effective Date / /		Effective Date / /		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 qualify 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	
Effective Date / /		Effective Date / /		Effective Date / /	
From: _____ To: _____		From: _____ To: _____		From: _____ To: _____	
Effective Date / /		Effective Date / /		Effective Date / /	
Reinstate Insurance		Prior Effective Date of Termination		Effective Date / /	
Cancel ALL Coverage <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Leave/Lay Off		Effective Date / /		Name of other Insurance Company	
Address of other Insurance Company		Name 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 <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number		
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Relationship	Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Relationship	Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Relationship	Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Relationship	Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Relationship	Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent's Name	Date of Birth (Mo./Day/Yr.)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	Relationship	Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No

EMPLOYEE SIGNATURE _____ DATE _____

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.