

Legal Name: PHA Group Benefit Trust  
Version: PHBT / CT / 0308

## EXISTING MEMBER CHANGE/TERMINATION FORM

Please complete this form in "BLACK" ink only and print legibly

### SECTION I. GENERAL INFORMATION

Applicant Social Security No.    -   -

Group No.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Location: \_\_\_\_\_

### SECTION II. CHANGE IN EMPLOYEE INFORMATION

New Name: \_\_\_\_\_

New Address: \_\_\_\_\_

New Phone : \_\_\_\_\_

### SECTION III. CHANGE IN CURRENT COVERAGE (subject to the plan provisions and plan options selected by your employer)

Health Plan	
<b>Change from:</b>	<b>Change to:</b>
<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee Only
<input type="checkbox"/> EE + Spouse	<input type="checkbox"/> EE + Spouse
<input type="checkbox"/> EE + Child(ren)	<input type="checkbox"/> EE + Child(ren)
<input type="checkbox"/> EE + Family	<input type="checkbox"/> EE + Family

### SECTION IV. CHANGE IN FAMILY INFORMATION (please complete for all persons to be covered)

First Name & M.I. (last name if different)	Sex	DOB	F/T Student* (Y/N)	Height	Weight	Social Security No.
Spouse:	M / F	/ /				/ /
Child:	M / F	/ /				/ /
Child:	M / F	/ /				/ /

Special Enrollment Event\*\*

Marriage  Loss of Coverage  Newborn/Adoption | Event Date: \_\_\_\_\_

\* Full time students ages 19 - 24. Student certification required from accredited college. Contact the Plan Administrator for a Student Status form.

\*\* The Plan Administrator may require proof of Special Enrollment Event.

### SECTION V. TERMINATION OF COVERAGE

Terminate ALL Coverage | Terminate ONLY the following coverage(s):  Health  Dental  Vision  STD

Reason for Termination of Coverage:

Termination of Employment  Reduction in Hrs  Death  Has other Coverage  Divorce/Legal Separation  Other \_\_\_\_\_

Event Date: \_\_\_\_\_

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

Employer Signature/Verification: \_\_\_\_\_ Date: \_\_\_\_\_