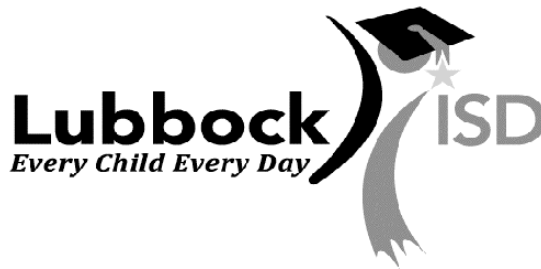


**2020
Medical Plan
Change Form**



EID# _____
Effective Date _____

Name of Employee _____

SS# (_____) BCBS-ID# (_____) DOB (M/D/Y) _____

Home Address _____

Building or Organization _____ Position _____

Coverage Level	Bronze-PPO	Bronze-HMO	Silver-PPO	Silver-HMO	Hospital Income Plan	
	(\$6,650 Individual Deductible)		(\$4,000 Individual Deductible)			\$
Employee Only	<input type="radio"/> \$144	<input type="radio"/> \$113	<input type="radio"/> \$337	<input type="radio"/> \$280	<input type="radio"/>	\$0
Employee & Children	<input type="radio"/> \$234	<input type="radio"/> \$181	<input type="radio"/> \$498	<input type="radio"/> \$407	For employee only, choose	
Employee & Spouse	<input type="radio"/> \$295	<input type="radio"/> \$227	<input type="radio"/> \$649	<input type="radio"/> \$532	this option if you have major	
Employee & Family	<input type="radio"/> \$468	<input type="radio"/> \$371	<input type="radio"/> \$940	<input type="radio"/> \$777	medical elsewhere.	

* HSA – Health Savings Account – ask about enrollment information if you select either Bronze Plan.

Reason for Change: <i>(Children may be covered to the 26th birthday.)</i>	From:	To:
<input type="checkbox"/> Newly Married *** (Date) _____	<input type="checkbox"/> Bronze-PPO	<input type="checkbox"/> Bronze-PPO
<input type="checkbox"/> Divorced (Date) _____	<input type="checkbox"/> Bronze-HMO	<input type="checkbox"/> Bronze-HMO
<input type="checkbox"/> Newborn ** (Date) _____	<input type="checkbox"/> Silver-PPO	<input type="checkbox"/> Silver-PPO
<input type="checkbox"/> Spouse Employment Change (Date) _____	<input type="checkbox"/> Silver-HMO	<input type="checkbox"/> Silver-HMO
<input type="checkbox"/> Dependent Ineligible	<input type="checkbox"/> HIP	<input type="checkbox"/> HIP
<input type="checkbox"/> Coverage Loss (End Date) _____		
<input type="checkbox"/> Cancel Dependent (End Date) _____		
<input type="checkbox"/> Other (please specify) _____		

Dependent Coverage			Please Circle Action Desired	
NAME	SS#	Date of Birth	Add	Drop
Husband <input type="checkbox"/>	_____	_____		
Wife <input type="checkbox"/>	_____	_____		
Son <input type="checkbox"/>	_____	_____		
Daughter <input type="checkbox"/>	_____	_____		
Son <input type="checkbox"/>	_____	_____		
Daughter <input type="checkbox"/>	_____	_____		
Son <input type="checkbox"/>	_____	_____		
Daughter <input type="checkbox"/>	_____	_____		
Son <input type="checkbox"/>	_____	_____		
Daughter <input type="checkbox"/>	_____	_____		

**Newborn children are covered from date of birth if added within 31-days of birth.
***Spouses are covered from date of marriage if added within 31-days of marriage.

Signature _____ Date _____

I hereby request a change in coverage as indicated above and authorize the appropriate monthly payroll deduction.