



EMPLOYEE CHANGE/TERMINATION FORM

P.O. Box 7777, Lancaster, PA 17604-7777
 Tollfree: 800-796-7460 Fax: 717-581-1319

Mail completed form to Significa at the above address.

Complete for all changes and/or terminations.

Employee's last name, first name, middle initial:		Social Security Number:	
Residential address: <input type="checkbox"/> Check if new address.	State:	ZIP:	Home phone number:
Company/Employer name:			Group number:
Employee signature (If employee is not available to sign, write: "Not available for Signature" and sign your own signature.)			
Date:			
A. Name change	From:	To:	
B. Smoker status change	The employee is now a - <input type="checkbox"/> Non-smoker <input type="checkbox"/> Smoker To be a non-smoker the employee must have had stopped smoking for a 12-month period.		
C. Coverage waiver	Important: The employee understands that if coverage is waived and insurance is applied for a later date, he/she and any dependents may be treated as a "Late" enrollment under the terms of the plan/policy.		
The employee has been given an opportunity to apply for group insurance and has decided not to elect coverage for:			
<input type="checkbox"/> Employee <input type="checkbox"/> Dependents <input type="checkbox"/> Employee and dependents <input type="checkbox"/> Spouse only <input type="checkbox"/> _____			
Type of coverage declined:		Reason:	
Is spouse insured through another employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of insurance company:	
If "Yes" – Employer name:			Policy number:

Sections D and E are to be completed by the employer only.

D. Employee status changes:	Effective date of change (mm/dd/yy): / /
<input type="checkbox"/> Class or position change	The employee is now in the following new class or position:
<input type="checkbox"/> Reinstatement	Reinstate coverage for the employee – Reason: (If applicable, rehire date(mm/dd/yy)): / /
<input type="checkbox"/> FMLA leave	Begin date (mm/dd/yy): / / Expected return date (mm/dd/yy): / /
E. Termination notice and notice of conversion privilege	Terminate: <input type="checkbox"/> Employee <input type="checkbox"/> Dependent(s) only Dependent(s) name(s): Effective date of termination (mm/dd/yy): / / Reason:

Important: All claims prior to the termination date must be submitted within 90 days after employment ends. Please be aware that your coverage has terminated in accordance with the terms of the group plan on the above date. If applicable, under a conversion privilege contained in the group plan, it may be possible for you to obtain an individual insurance policy. If interested in obtaining this coverage, please call to initiate the process or write to us immediately, giving a current address and enclosing a copy of this notice.

Policyholder authorized signature: _____ Date: _____
 (applies to all changes above)