Change/Update form

32162368 (12/18)

PLEASE PRINT CLEARLY

Section 1 Account holder information

* **This information is mandatory.** Form processing may be delayed if fields with an asterisk are not filled out.

* First name	M.I.	* Last name	* Date of birth ______ /______ / ____________	* SSN or BHS Identification number	
* Mailing address		* City		* State	* ZIP
* Email address			* Contact phone number		
* Group name					

Section 2 Application Reason

Effective date _____ /_____ / ____________

- ☐ Name change only ______________________
- ☐ New address ______________________
- ☐ Adding dependent ______________________
- ☐ Deleting dependent ______________________
- ☐ Changing carriers due to moving out of service area ______________________
- ☐ Adding benefit due to status change/open enrollment ______________________
- ☐ Terminating coverage (list benefit and reason for termination) ______________________
- ☐ Other ______________________

Section 3 Eligible dependents

If you are adding a newborn, please contact BenefitHelp Solutions when you receive your dependent's SSN.

☐ Add ☐ Remove	* First name	* Last name	☐ Male ☐ Female	* SSN	* Date of birth _____ /_____ / __________	* Relationship
☐ Add ☐ Remove	* First name	* Last name	☐ Male ☐ Female	* SSN	* Date of birth _____ /_____ / __________	* Relationship
☐ Add ☐ Remove	* First name	* Last name	☐ Male ☐ Female	* SSN	* Date of birth _____ /_____ / __________	* Relationship
☐ Add ☐ Remove	* First name	* Last name	☐ Male ☐ Female	* SSN	* Date of birth _____ /_____ / __________	* Relationship
☐ Add ☐ Remove	* First name	* Last name	☐ Male ☐ Female	* SSN	* Date of birth _____ /_____ / __________	* Relationship

Section 4 New carrier information

Plan type	New carrier	Previous carrier
Medical		
Dental		

Section 5 Authorization

I have read and agree to the terms and conditions shown above.	
* Signature	* Signature date

Please return to your human resources or benefits department upon completion.

Questions? Contact BenefitHelp Solutions at 888-398-8057.