ADVENTIST RISK MANAGEMENT, INC.

Providing Solutions to Minimize Risks

HEALTH CARE
EMPLOYEE BENEFITS
CHANGE REQUEST

This form is to be completed only when a change needs to be made for an existing employee. Do not complete this form to add a new employee; an enrollment application must be completed for this purpose. However, this form may be used to add or terminate a spouse or child and to terminate an existing employee. This form may be completed by the employee, but must be signed by the employer before it is sent to Adventist Risk Management, Inc. – Health Benefits Services.

EMPLOYEE INFORMATION

Name:_____Social Security #:_____

CHANGE(S) TO BE MADE *MARK CHOICE ONLY (Please do not add and terminate on the same form)*

Name: □ Address: □ Phone Number: □ Add Spouse: □ Add Child/ren: □

Terminate Employee/Family: □ Terminate Spouse: □ Terminate Child/ren: □

CHANGE DETAILS *(Fill in details for above marked choice)*

- Employee Information

New Name:_____New Phone #:(___)_____ _____
Last First M.I.

New Address:_____
Street City State Zip

- Spouse Information

Name:_____Birth Date:_____ Social Security #:_____
MM/DD/YEAR

Employer Name:_____Employer Address:_____

Other Insurance: □ Yes □ No
Company:_____Address:_____
Effective Date:_____ Is this primary or secondary coverage?:_____
MM/DD/YEAR

- Children Information

First Name	M.I.	Last Name	Birth Date	Sex	SSN #	Other Ins ?
				□ M □ F		
				□ M □ F		
				□ M □ F		
				□ M □ F		

Other insurance name:_____ Phone #:_____Effect. Date:_____

Employee's Signature:_____ Date:_____

AUTHORIZED EMPLOYER'S SIGNATURE REQUIRED

Effective Date	Employer Name	Group #	Subgrp #

Employer's signature:_____

Date: _____ Coverage Code: _____

Received On:

	DATE COMPLETED
IBC	
TRANS#	
CARD	□IBC
CARD	□ARM
VERIFIED	□IBC □AHA □MEDCO
HIPAA	

ARM OFFICE USE ONLY

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