SET SEG
School Insurance Specialists

SUBSCRIBER CHANGE FORM REQUEST

INSTRUCTIONS: Please indicate only the change(s) you are reporting at this time. This change form request will facilitate the change(s). **A new application is not necessary.** The change will not be valid unless this form is signed and dated by the employee.

For SET Fringe Benefit Plans: _____
SUBSCRIBERS NAME (LAST, FIRST) SOCIAL SECURITY NUMBER EMPLOYER GROUP NUMBER

SECTION ONE: GENERAL *Please print*

A) Name Change To: _____
NAME (LAST, FIRST) EFFECTIVE DATE

B) Address Change To: _____
ADDRESS EFFECTIVE DATE

C) Job Title of Position Change: _____
NEW TITLE OR POSITION NEW SALARY EFFECTIVE DATE

SECTION TWO: DEPENDENT STATUS CHANGE

NAME: (FIRST, LAST)	GENDER	SOCIAL SECURITY NO. (MANDATORY FOR SPOUSE)	BIRTHDATE MM/DD/YY	RELATIONSHIP	ADD	DELETE	REASON* (SEE BELOW)	INSURANCE AFFECTED (CHECK ALL THAT APPLY)	OTHER INS. (CHECK)	EFFECTIVE DATE
								❍MEDICAL ❍DENTAL ❍VISION	YES NO	
								❍MEDICAL ❍DENTAL ❍VISION	YES NO	
								❍MEDICAL ❍DENTAL ❍VISION	YES NO	

*Please insert the corresponding number as it applies to this change: (1) Marriage (2) Divorce (3) Employment (4) Continue Education (5) Death (6) Birth (7) Delete Dependants (8) Legal Guardianship (9) Voluntary Cancellation (10) Other (please explain)_____

If you named a child, above, whose birth parents are divorced or separated, is there a court order stating which parent is responsible for providing health insurance (Please attach a copy of the court order)? ❍ YES (IF YES, ❍ FATHER ❍ MOTHER) ❍ NO

NAME OF SUBSCRIBER SOCIAL SECURITY NUMBER DATE OF BIRTH EMPLOYER

NAME OF MEDICAL INSURANCE CO. NAME OF DENTAL INSURANCE CO. NAME OF VISION INSURANCE CO.

SECTION THREE: ELIGIBLE FOR MEDICARE

My dependent,_____, is eligible for Medicare Plans A and B, prior to the attainment of age 65.
FULL NAME

Medicare coverage is effective as of,_____
MONTH DAY YEAR

SECTION FOUR: COORDINATION OF BENEFITS

Do you, your spouse or dependents have dental or vision coverage through another source? Check all that apply: ❍ DENTAL ❍ VISION

NAME OF SUBSCRIBER SOCIAL SECURITY NO. DATE OF BIRTH EMPLOYER

❍ FAMILY ❍ SINGLE

DENTAL INSURANCE COMPANY NAME EFFECTIVE DATE

❍ FAMILY ❍ SINGLE

VISION INSURANCE COMPANY NAME EFFECTIVE DATE

AUTHORIZATION:

❍I hereby understand that I am authorizing SET, Inc. to revise my Group Insurance coverage record(s) in accordance with the Change Request Form designation. Further, the effective date of the request(s) will be determined by my eligibility and the underwriting policies of the Union Security Insurance Company, Blue Cross and Blue Shield of Michigan or other insurers as applicable, and any additional contribution required may be deducted from my earnings.

DATE SIGNATURE OF EMPLOYEE NAME OF EMPLOYER

Do you need to change or update your life insurance beneficiary? You can obtain a form by emailing enrollment@setseg.org or by logging in at www.setseg.org and choosing "Standard Forms" under the Employee Benefit Services tab.

Signed form must be received within 30 days of requested effective date.

Upload to www.setseg.org by logging in and choosing "Upload Employee Enrollment Forms" from the Employee Benefit Services menu, or email enrollment@setseg.org