SET SEG
School Insurance Specialists

GROUP INSURANCE CHANGE FORM REQUEST

SET SEG • 415 W. Kalamazoo • Lansing, Michigan 48933 • 1-800-292-5421

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 ULTRA-MED PREFERRED, GROUP OPTIONS, DENTAL, AND VISION COVERAGES ONLY.

EMPLOYEE INFORMATION:

Name_____Social Security No._____-_____-_____
LAST FIRST

SECTION I: GENERAL

a) NAME CHANGE: To:_____
LAST FIRST

b) ADDRESS CHANGE: To: _____
STREET NAME & NUMBER

_____
CITY STATE ZIP

c) MARITAL STATUS CHANGE: ☐ Married; Date_____ ☐ Divorced; Date_____ ☐ Legally Separated; Date_____

d) JOB TITLE OR POSITION CHANGE: To:_____Date:_____

e) CANCELLATION OF EMPLOYER-PROVIDED INSURANCE PLAN DATE_____ COMPLETE SECTION II BELOW

SECTION II: DEPENDENT STATUS CHANGE

Name *(first)* Last *(if different)*	Sex M F	Social Security #	Birthdate MM/DD/YY	Relationship	Add	Delete	Reason* *(see below)*	Insurance Affected (Medical, Dental, Vision)	Other Insurance 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) 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? ☐ Yes ☐ No (Please attach a copy of the court order) With whom does the child reside? ☐ Father ☐ Mother
If subscriber has answered "Yes" to "Other Insurance," please complete and attach the SET Co-ordination of Benefits Form.

SECTION III: 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

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 Blue Cross Blue Shield of Michigan and /or Associated Mutual Hospital Service of Michigan, and any additional contribution required may be deducted from my earnings.

Date_____Signature of Employee_____

Signature of Employer_____

SET USE ONLY: Effective Date_____ Approved By_____ Date_____