CENTRAL INDIANA SCHOOL EMPLOYEE'S INSURANCE TRUST
EMPLOYEE CHANGE FORM - UNITED HEALTHCARE

Name ______________________ Social Security # ______________________

REQUEST FOR CHANGE: Indicate below the information you wish to change

☐ Name change from ______________________ to ______________________
Effective date of change ______________________

☐ Address change to Street ______________________
City, State Zip ______________________
Effective date of change ______________________

IMPORTANT: Please mark the reason for a status change:

☐ Marriage ☐ Divorce ☐ Spouse Deceased ☐ Birth/Adoption ☐ Termination of employment

Date of status change event: ______________________

☐ I wish to add the following coverages effective ______________________
Employee: ☐ Medical
Dependent(s): ☐ Medical

☐ I wish to terminate the following coverages effective ______________________
Employee: ☐ Medical
Dependent(s): ☐ Medical

☐ Dependent status change
☐ I wish to drop the below listed dependent(s) from my coverage effective ______________________
☐ I wish to add the below listed dependent(s) from my coverage effective ______________________

First Name	MI	Last Name	Birth Date	Social Security #	Relationship		Sex	Other Group Coverage	Disabled child?
					Spouse		☐ M ☐ F		
					☐ Son ☐ Step	☐ Daughter ☐ Other	☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No
					☐ Son ☐ Step	☐ Daughter ☐ Other	☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No
					☐ Son ☐ Step	☐ Daughter ☐ Other	☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No
					☐ Son ☐ Step	☐ Daughter ☐ Other	☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No

If the relationship of a dependent is an adopted child or child for whom you have legal custody, you must provide a copy of the legal papers.

The information completed above supersedes all prior requests.

Sign Here X ______________________ Date ______________________

Your coverage is issued by a multiple employer welfare arrangement. The multiple welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State guaranty funds are not available for your multiple employer welfare arrangement.

Employers Statement (to be completed by employer)

School Corp: Shelbyville

Employer Authorization ______________________ Date ______________________