



# ENROLLMENT CHANGE FORM

P.O. Box 91110  
 Sioux Falls, SD 57109  
 (605) 328-6800 • 1-800 752-5863  
 Fax: (605) 328-6812  
 sanfordhealthplan.com

**Employer Name:** \_\_\_\_\_ **Division Number:** \_\_\_\_\_  
**Employee Name:** \_\_\_\_\_ **Member ID #:** \_\_\_\_\_  
**Employee current address:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Change Request (All changes must be requested within 31 days of the date of event)**

**Effective Date of Change\*:** \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Coverage will typically begin the first day of the month following the date of event. Coverage will typically end the last day of the month following the date of event.

**Involuntary Cancellation Request – Cobra Continuation rights will be offered by Sanford Health Plan**

- Employment ended. Last day worked: \_\_\_\_\_
- Reduction in hours causing the employee to lose benefits
- Leave of absence causing the employee to lose benefits
- Lay-off causing the employee to lose benefits
- Divorce or legal separation. Spouse Name: \_\_\_\_\_ Date of divorce: \_\_\_\_\_  
 Address of Spouse: \_\_\_\_\_
- Dependent is no longer eligible for coverage (please check one):  Graduation Date: \_\_\_\_\_  Loss of full-time student status
- Death of covered employee
- Retirement: Retiree benefits are not available or employee is not eligible.
- Military Leave/USSERA

**Voluntary Cancellation Request – Cobra Continuation rights will not be offered by Sanford Health Plan**

- Reduction in hours allowing employee to voluntarily cancel benefits
- Leave of absence allowing employee to voluntarily cancel benefits
- Death of covered dependent: Name: \_\_\_\_\_ Date of Death: \_\_\_\_\_
- Employee's entitlement to Medicare
- Voluntary coverage cancellation of dependent or spouse (must specify reason): \_\_\_\_\_  
 List all dependents to be removed from policy: \_\_\_\_\_
- Voluntary coverage cancellation of Employee and all dependents (must specify reason): \_\_\_\_\_

**Other Policy Change Requests**

- Retirement: Employee is eligible for retirement benefits and is to remain on the policy as a retiree.
- Change in Deductible/Benefit Package Type from: \_\_\_\_\_ to: \_\_\_\_\_  
 Note: Deductibles can only be changed during Open Enrollment or during a separate qualified life event which must be specified.
- Name Change from: \_\_\_\_\_ to: \_\_\_\_\_
- Change of Address: \_\_\_\_\_
- Other Change: \_\_\_\_\_
- Addition of Spouse or Dependent (must specify reason): \_\_\_\_\_

Last Name	First/M.I.	Address (if different)	Birth Date*	Gender (M/F)	Social Security #	Relation

1. \*If child is over the age of 19, please attach proof of full-time student status. School Name: \_\_\_\_\_
2. Has anyone listed above had previous health insurance coverage in the past 63 days?  Yes  No  
 If yes, please complete information below or attach a Certificate of Creditable Coverage. If requested information is missing or incomplete, an assumption will be made that no prior creditable coverage existed and a pre-existing limitation may apply.

3. Will anyone listed above be insured on another health insurance policy besides this one?  Yes  No If Yes, list:
 

Covered Individuals	Insurance Company	Effective Date	Cancellation Date
---------------------	-------------------	----------------	-------------------

Covered Individuals	Policy Holder	Effective Date	Insurance Company
---------------------	---------------	----------------	-------------------

**EMPLOYEE SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**EMPLOYER SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_