

BCBS _____ VISION _____
Date: _____
Initials: _____

CULLMAN COUNTY COMMISSION INSURANCE DEPENDENT CHANGE FORM (Medical/Dental/Vision)

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)			Date of Birth		
Social Security Number		Department		Contract Number	
Home Telephone Number ()					
DROP DEPENDENT COVERAGE <input type="checkbox"/> Change from Family to Single Coverage <input type="checkbox"/> Cancel dependent(s) listed below from Family Coverage			ADDITIONS – PROVIDE DOCUMENTATION **Please read important information on the back. <input type="checkbox"/> Change from Single to Family Coverage. Add dependent(s)** <input type="checkbox"/> Add dependent(s) listed below to Family Coverage **		
REASON FOR CANCEL		MONTH/DAY/YEAR		REASON FOR ADDITION	
<input type="checkbox"/> Death		_____		<input type="checkbox"/> Marriage	
<input type="checkbox"/> Divorce		_____		<input type="checkbox"/> Birth of Child	
Attach divorce decree		_____		<input type="checkbox"/> Adoption of Child	
<input type="checkbox"/> Dependent no longer eligible		_____		<input type="checkbox"/> Other	
Explain: _____		_____		Explain: _____	
<input type="checkbox"/> Other:		_____		Explain: _____	
Explain: _____		_____		_____	

First Name	Initial	Last Name	Documentation is required. See back of form. Relationship to Employee		Date of Birth	Social Security Number
			<input type="checkbox"/> Male Spouse	<input type="checkbox"/> Female Spouse		
			<input type="checkbox"/> Son <input type="checkbox"/> stepson	<input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson	<input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson	<input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson	<input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson	<input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		
			<input type="checkbox"/> Son <input type="checkbox"/> Stepson	<input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter		

For additional dependents, please list the information on a separate sheet and attach to this form.

<p style="text-align: center;">TO BE COMPLETED BY EMPLOYER</p> <p>Effective Date of Change: _____</p> <p>Notes: _____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;">AFFIRMATION AND RELEASE</p> <p>I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity, or representative acting on the Cullman County Commission's behalf.</p> <p style="text-align: center;">_____ Employee Signature</p> <p style="text-align: center;">_____ Date</p>
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Dependent documentation is required before dependents can be added to coverage.

GENERAL INFORMATION

Eligible Dependent

(Appropriate documentation must be attached.)**

The term "dependent" includes the following individuals subject to appropriate documentation such as a Social Security number, marriage certificate, birth certificate, court decree, etc.

1. Your spouse (excludes divorced spouse).
2. A child under age 26, only if the child is:
 - a. your son or daughter. (A court decree establishing paternity will be temporarily effective for 60 days, at which time an amended birth certificate listing the father's name will be due.)
 - b. a child legally adopted by you or your spouse,
 - c. your stepchild,

****Documentation Required to Add Dependents to Your Health Coverage**

1. Spouse – Copy of marriage certificate, copy of spouse's social security card. (Effective 1/1/2017 common-law marriage is no longer recognized in the State of Alabama)
2. Dependent Child (under age 26) – Copy of child's birth certificate, copy of child's social security card. Copy of court order granting custody of child to you or your spouse (if applicable).

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