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Change Request Form

Group Premium and Enrollment Services
Underwritten by: United of Omaha Life Insurance Company • Mutual of Omaha Insurance Company

To Be Completed By Employer Or Plan Sponsor

Employer's Company Name Cullman County Commission, Alabama City Cullman State AL Zip 35055

Sub-Group Name _____ Dept /Location _____ Class _____

Group I.D. G000AMG8 Sub-Group I.D. _____

To Be Completed By Employee (Please Print)

Social Security Number ___-___-___ Name _____

Coverage(s) affected: ☐ Life/AD&D ☐ Voluntary Term Life

Employee Change(s)

	From	To	Effective Date Mo. Day Yr.
☐ Name[1]			___/___/___
☐ Salary			___/___/___
☐ Sub-Group			___/___/___
☐ Class[1]			___/___/___
☐ Address	Address / Zip Code		
	City / State		___/___/___

[1]Reason: _____

Terminate Insurance: Effective Date Mo. Day Yr.

Reason (specify) _____ ___/___/___

Reinstatement of Insurance: Effective Date Mo. Day Yr.

Date Returned to Work ___/___/___

Date Previously Canceled[2] ___/___/___

[2]Reason for Previously Cancellation: (check one)

☐ Layoff
☐ Disability
☐ Leave of Absence
☐ Other (specify) _____

Dependent Event Change(s) (Both Event Reason And Date Of Event Must Be Completed)

Event Reason: ☐ Marriage ☐ Birth ☐ Adoption ☐ Step-child(ren)[3] ☐ Divorce ☐ Death

☐ Loss of Coverage (must specify reason) _____

☐ Other (must specify reason) _____

Date of Event: ___/___/___ **Amount of Life Volume for new dependent(s):** Spouse $_____ Child(ren) $_____

Change Life Volume: Employee from $ _____ to $ _____ ; Spouse from $_____ to $_____; Child(ren) from $_____ to $_____

ADD	DELETE	Name of Dependents	Sex	Relationship	Birthdate Mo. Day Yr.	Social Security No.
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					

Indicate ALL Dependent(s) Covered AFTER Change(s) above is (are) Made: (check one only)

☐ Spouse ☐ Child ☐ Children ☐ Spouse and Child(ren) ☐ No Dependent Coverage

See your benefits administrator for the required form(s):
If the dependent(s) listed is not your natural child, please complete the Statement of Responsibility for a Dependent Child form and submit with this enrollment form.
If dependent is 19 years of age or older (unless otherwise stated in the plan) and a full-time student, complete a Student Dependent Attendance Report form and submit with this enrollment form.

Other Insurance

Do you or any of your dependents have coverage under **any other health plan** that you will retain **after** enrolling in this health plan? ☐ Yes ☐ No

If yes, please provide the following information about your/their other insurance coverage:

Primary Covered Individual	Who is covered? (i.e. employee, spouse, dependent's name)	Name of Employer offering Other Insurance	Other Insurance Company Name	Policy Number	Effective Date	Type of Health Coverage(s) (Medical, Dental, Medicare, Medicaid)

INSURANCE COMPANY USE ONLY

___/___/___
Effective Date Of Change

Instructions: If you want to add a new dependent to this plan, you must make written request for dependent coverage by completing this Change Request Form. You must return this form to your plan administrator. To add an eligible dependent you must make your written request within 31 days (or as otherwise stated in the plan) after such dependent becomes eligible under the terms of this group plan. If your written request is made after 31 days, your eligible dependent may be considered a late enrollee and may be subject to additional conditions as stated in the plan. If the plan is contributory, this form **must** be signed and dated to authorize payroll deductions.

I represent that the information I have provided in this Change Request Form is complete, true and accurate, to the best of my knowledge.

Signature of Employee _____ **Date** ___/___/___

Authorization To Disclose Personal Information

1. I authorize any physician, medical or dental practitioner, hospital, clinic, pharmacy benefit manager, other medical care facility, health maintenance organization, insurer, employer, consumer reporting agency and any other provider of medical or dental services to release records containing the personal information of:

   Applicant Name: _____
   (Last) (First) (Middle)

2. Personal information includes medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information.

3. You may release information to:

   Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
   Attn: Group Insurance Underwriting Individual Selection
   Mutual of Omaha Plaza
   Omaha, NE 68175-0001

   or

   Fax 402-351-2537

4. I understand that the personal information that is disclosed will be used by Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to evaluate my application and that if I refuse to sign this authorization my application may not be approved.

5. I understand that if the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the personal information may be redisclosed without the protection of the federal privacy regulations.

6. This authorization will expire 24 months after the date signed.

7. I understand that I may revoke this authorization at any time by providing a written request to Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company at the address above. If I revoke this authorization, it will not affect any use or disclosure of personal information that occurred prior to the receipt of my revocation.

8. I understand that I am entitled to receive a copy of this authorization and that a copy is as valid as the original.

RETAIN A SIGNED COPY FOR YOUR RECORDS

Name(s) used for records (if different than the name below): _____

_____

_____ _____
Signature of Applicant Date

If Applicable: I am the legal representative of the applicant and I am authorized to grant permission on behalf of the applicant.

Printed Name of Legal Representative: _____

Signature of Legal Representative: _____

Type of Legal Representative: _____

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

MUGC9252