



Medical Change Form (PLEASE PRINT)

EMPLOYER NAME ET Investments, LLC		GROUP NUMBER L12521M006	EMPLOYEE DATE OF HIRE	3 Letter Company Code
SOCIAL SECURITY NUMBER			EMAIL ADDRESS	
NAME: LAST		FIRST	M.I.	
ADDRESS		CITY	STATE	ZIP
DATE OF BIRTH	GENDER	MARITAL STATUS	HOME TELEPHONE NUMBER	

PLEASE SELECT ONE MEDICAL PLAN OPTION and COVERAGE TYPE BELOW:

MEDICAL PLAN OPTION:				
PMED PPO Premium Plan	SMED PPO Standard Plan	HMED PPO High Ded Plan	HSA	
COVERAGE TYPE:				
EE only	EE + spouse	EE + child(ren)	Family	Waive

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

Spouse Name			SS#	BIRTH DATE	GENDER	RELATIONSHIP TO EMPLOYEE
First	MI	Last				
_____			____-____-____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<u>SPOUSE</u> (Child/Step-child/Adopted child/ Foster/ Legal guardianship /QMCSO)
Child/ren						
1 _____			____-____-____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
2 _____			____-____-____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
3 _____			____-____-____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
4 _____			____-____-____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
5 _____			____-____-____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	_____

COMPLETE THIS SECTION IF MAKING CHANGES

Effective date of change: _____ **Please specify change reason and update in appropriate section.**

Qualifying event reason:

☐ Date of Loss of Prior Insurance Coverage _____

☐ Employee name change

☐ Employee address change

☐ Date of marriage _____

☐ Date of Divorce _____

☐ Eligible for Medicaid/CHIP subsidy/Medicare

☐ Loss of Eligibility for Medicaid/CHIP subsidy

☐ Add dependents

☐ Remove dependents (list names) _____ Reason: _____

As of the effective date of this Medical insurance, will you or any member of your family being covered under this insurance, continue to be covered under another Medical insurance plan including Medicare.

☐ Yes, single ☐ Yes, Spouse/Children ☐ Yes, Family ☐ Yes, Children ☐ No

If YES to the above question, complete the following:

Person's name _____ Employer Name _____

Carrier Name _____ Plan Number _____

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved.

I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan.

Please refer to your Employee Benefit Booklet for specific detail of your benefit plan.

☐ I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

EMPLOYEE SIGNATURE

DATE