



SUBSCRIBER CHANGE FORM REQUEST

INSTRUCTIONS: Please indicate only the change(s) you are reporting at this time. This change form request will facilitate the change(s). **A new application is not necessary.** The change will not be valid unless this form is signed and dated by the employee.

For SET Fringe Benefit Plans:

SUBSCRIBERS NAME (LAST, FIRST) SOCIAL SECURITY NUMBER EMPLOYER GROUP NUMBER

SECTION ONE: GENERAL *Please print*

- A) **Name Change To:** NAME (LAST, FIRST) EFFECTIVE DATE
- B) **Address Change To:** ADDRESS EFFECTIVE DATE
- C) **Job Title of Position Change:** NEW TITLE OR POSITION NEW SALARY EFFECTIVE DATE

SECTION TWO: DEPENDENT STATUS CHANGE

NAME: (FIRST, LAST)	GENDER	SOCIAL SECURITY NO. (MANDATORY FOR SPOUSE)	BIRTHDATE MM/DD/YY	RELATIONSHIP	ADD	DELETE	REASON* (SEE BELOW)	INSURANCE AFFECTED (CHECK ALL THAT APPLY)	OTHER INS.	EFFECTIVE DATE
								<input type="radio"/> MEDICAL <input type="radio"/> DENTAL <input type="radio"/> VISION	YES NO	
								<input type="radio"/> MEDICAL <input type="radio"/> DENTAL <input type="radio"/> VISION	YES NO	
								<input type="radio"/> MEDICAL <input type="radio"/> DENTAL <input type="radio"/> VISION	YES NO	

*Please insert the corresponding number as it applies to this change: (1) Marriage (2) Divorce (3) Employment (4) Continue Education (5) Death (6) Birth (7) Delete Dependents (8) Legal Guardianship (9) Voluntary Cancellation (10) Other (please explain)

If you named a child, above, whose birth parents are divorced or separated, is there a court order stating which parent is responsible for providing health insurance (Please attach a copy of the court order)? YES (IF YES, FATHER MOTHER) NO

NAME OF SUBSCRIBER SOCIAL SECURITY NUMBER DATE OF BIRTH EMPLOYER

NAME OF MEDICAL INSURANCE CO. NAME OF DENTAL INSURANCE CO. NAME OF VISION INSURANCE CO.

SECTION THREE: ELIGIBLE FOR MEDICARE

My dependent, _____, is eligible for Medicare Plans A and B, prior to the attainment of age 65.
FULL NAME

Medicare coverage is effective as of, _____
MONTH DAY YEAR

SECTION FOUR: COORDINATION OF BENEFITS

Do you, your spouse or dependents have dental or vision coverage through another source? Check all that apply: DENTAL VISION

NAME OF SUBSCRIBER SOCIAL SECURITY NO. DATE OF BIRTH EMPLOYER

DENTAL INSURANCE COMPANY NAME EFFECTIVE DATE FAMILY SINGLE

VISION INSURANCE COMPANY NAME EFFECTIVE DATE FAMILY SINGLE

AUTHORIZATION:

I hereby understand that I am authorizing SET, Inc. to revise my Group Insurance coverage record(s) in accordance with the Change Request Form designation. Further, the effective date of the request(s) will be determined by my eligibility and the underwriting policies of the Union Security Insurance Company, Blue Cross and Blue Shield of Michigan or other insurers as applicable, and any additional contribution required may be deducted from my earnings.

DATE SIGNATURE OF EMPLOYEE NAME OF EMPLOYER

Do you need to change or update your life insurance beneficiary? You can obtain a form by emailing enrollment@setseg.org or by visiting our website at www.setseg.org/forms.

Signed form must be received within 30 days of requested effective date.