FBA
FIRST BENEFIT ADMINISTRATORS

PARTICIPANT STATUS CHANGE FORM

TYPE OF CHANGE
- ☐ Name Change
- ☐ Address Change
- ☐ Add Dependent
- ☐ Delete Dependant
- ☐ Terminate Coverage
- ☐ Delete Disability Coverage
- ☐ Delete Health Coverage
- ☐ Delete Dental Coverage
- ☐ Delete Life Coverage
- ☐ Other _____

EFFECTIVE DATE OF CHANGE _____

TYPE COVERAGE REQUESTED
- ☐ Employee
- ☐ Employee/Spouse
- ☐ Employee/Child(ren)
- ☐ Employee/Family
- ☐ Health & Life
- ☐ Health Only
- ☐ Life Only
- ☐ Dental
- ☐ Disability

REASON FOR CHANGE
- ☐ Marriage **
- ☐ Death **
- ☐ Terminate Employment **
- ☐ Divorce **
- ☐ Birth **
- ☐ Adoption **
- ☐ Overage Dependent
- ☐ Layoff
- ☐ Leave of Absence
- ☐ Return of Alternate Insurance
- ☐ Disability
- ☐ Other _____

** DATE OF EVENT _____

GENERAL INFORMATION

Employer Name	Group Number
Employee's Name (Last Name, First Name, Middle Initial)	FBA Employee ID

A copy of the court order must be attached for dependents in court-ordered custody or guardianship of the Employee

LIST ELIGIBLE DEPENDENTS TO BE COVERED (PLEASE PRINT) If more space is required, attach a separate sheet with additional information

Name(s) (Last, First, Middle Initial)	Date of Birth	Relationship	Social Security number

Reason for Deletion ☐ Age ☐ Divorce ☐ Marriage ☐ Dea
☐ Other – Please Explain:

Reason for Deletion ☐ Age ☐ Divorce ☐ Marriage ☐ Death
☐ Other – Please Explain:

Change in Beneficiary (Last, First, Middle Initial)	Dat	Relationship	☐ Add ☐ Delete
Change in Beneficiary (Last, First, Middle Initial)	Dat	Relationship	☐ Add ☐ Delete

☐ Name Change	Change Name From:	To:
☐ Address Change	New Address (Street, City, County, State, Zip)	Phone Number
☐ Other		

OTHER CARRIER LIABILITY INFORMATION – THIS SECTION MUST BE COMPLETED

On the day this coverage begins, will you or any dependants enrolling in this Plan be covered by any other group insurance or Medicare? ☐ Yes ☐ No
If yes, fill out the appropriate section(s) below. If more space is required, attach a separate sheet with additional information.

HEALTH	DENTAL	MEDICARE	
Participant Member's Name / Date of Birth	Participant's Member's Name / Date of Birth	Beneficiary Name	Beneficiary Name
Employment Status ☐ Active ☐ Retired / Name of Employer	Employment Status ☐ Active ☐ Retired / Name of Employer	Entitlement Reason ☐ Age 65 or older ☐ End Stage Renal Disease ☐ Other Disability	Entitlement Reason ☐ Age 65 or older ☐ End Stage Renal Disease ☐ Other Disability
Policy # / Effective Date / Type of Coverage ☐ Single ☐ Family	Policy # / Effective Date / Type of Coverage ☐ Single ☐ Family		
Name of Insurance Company / Phone # ( )	Name of Insurance Company / Phone # ( )	Medicare HIC Number	Medicare HIC Number
City, State and Zip Code of Claims Center	City State and Zip Code of Claims Center	Part A Effective Date	Part A Effective Date
Does the above insurance cover "all" family including you? ☐ Yes ☐ No If no, please list the names of all dependents covered?	Does the above insurance cover "all" family members you? ☐ Yes ☐ No If no, please list the names of all dependents not cove	Part B Effective Da	Part B Effective Date

I certify that the above information is complete and true and that those listed as such are legal dependents. I also authorize payroll deduction(s) from my salary For my contribution toward the cost of any of the Plan coverages. Pre-existing conditions will not be covered for twelve to eighteen months unless proof of Continuation of medical coverage is provided. Any person who knowingly and with intent to injure, defraud, or deceive any benefit plan, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree

_____ Employee Signature _____ Date _____ Employer Signature _____ Date

PRIVACY/CONFIDENTIALITY NOTE: The information contained on this form is legally privileged and confidential. It is intended only for the use of the employer and/or claims administrator. If you are not the intended recipient of this form, you hereby are notified that any dissemination, distribution, downloading or copying of the contents is strictly prohibited. If you are the intended recipient(s) you will need to secure the contents conforming to all applicable state and/or federal requirements relating to the privacy and confidentiality of such information, including the HIPAA Privacy guidelines. FBA does not accept any liability for any errors or omissions in the contents of this form.

A COPY OF THIS COMPLETED FORM SHOULD BE RETAINED FOR YOUR FILES AND THE ORIGINAL RETURNED TO YOUR HUMAN RESOURCES OFFICE OR YOUR BENEFITS ADMINISTRATOR

THEN MAIL OR FAX THE COMPLETED SIGNED FORM TO: **FIRST BENEFIT ADMINISTRATORS, INC**
9455 Koger Blvd. N. Suite 100, St. Petersburg, FL 33702
Phone: 727.530.4144 ◊ Fax: 727.532.9602
www.firstbenefitadmin.com