

**PREFERRED HEALTH SYSTEMS INSURANCE COMPANY ("PHSIC") P.O. Box 49288 • Wichita, KS 67201-9288  
CHANGE/TERM FORM (316) 609-2390 • Outside Wichita 1-800-660-8114 • Fax 316-609-2327**

Check the box(es) below that apply and complete the form as indicated

- Name Change - 1, 2, 5
- Address Change - 1, 3
- Add Dependent Spouse - 1, 3, 4, 5
- Add Dependent Child(ren) - 1, 3, 4, 5 (Please list address if different than employees)
- Terminate Dependent Spouse - 1, 3, 4, 5
- Terminate Dependent Child(ren) - 1, 3, 4, 5
- Terminate All Coverage - 1

Employer Name / Group Number \_\_\_\_\_

1. SSN	Employee's Legal Last Name	Legal First Name	M.I.	Sex
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Home Phone	Work Phone	2. Previous Name if Name Change
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3. Current Street Address	Apt. #	City	State	Zip
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4. Relationship	Legal Last Name Address (if different)	Legal First Name	M.I.	Sex	Date of Birth	SSN

5. Are you or any person listed above totally disabled?  Yes  No If so, who is disabled? \_\_\_\_\_

Are you or any person listed above covered by other health insurance?  Yes  No

If yes, what insurance \_\_\_\_\_ Insurance Company phone number \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Policyholder's Date of Birth \_\_\_\_\_ Policyholder's I.D.# \_\_\_\_\_

Names of those covered \_\_\_\_\_

I hereby apply for amendment to my enrollment. It is mutually agreed that these changes shall become effective on the date in accordance with the Group Health Insurance Policy, subject to PHSIC's approval of the change. In the event PHSIC does not approve the change, it may in its sole discretion (a) void the change and refund any premium or collect additional premium or (b) cancel the change form from the date of disapproval forward. I hereby consent to the release of information or medical records concerning services or supplies provided to me or my covered dependents by any health care provider, allied health professional, hospital or medical care institution to PHSIC, or its designee for the purpose of quality or utilization review or payment of a claim. A copy of this consent is available upon request. The consent is valid for the duration of the coverage. I represent that the information I have provided on this form is correct and that I do hereby agree to the terms and conditions set out in the plan.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**MUST BE COMPLETED, SIGNED AND DATED BY EMPLOYER**

**Reason for Change/Termination:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Marriage<br>Date of marriage _____                          | <input type="checkbox"/> Newborn<br>Date of birth _____                                       | <input type="checkbox"/> Loss of Other Coverage<br>Date of loss _____                           |
| <input type="checkbox"/> Common Law Marriage ( <i>attach affidavit</i> )             | <input type="checkbox"/> Newborn Adoption<br>Date placed in home _____                        | <input type="checkbox"/> No Longer Eligible Dependent/Student<br>Date of eligibility loss _____ |
| <input type="checkbox"/> Open Enrollment   | <input type="checkbox"/> Non-Newborn Adoption<br>Date placed in home _____                    | <input type="checkbox"/> Employment Terminated<br>Date of termination _____                     |
| <input type="checkbox"/> Divorce<br>Date of divorce _____                            | <input type="checkbox"/> Other reason (Please list reason) _____<br>_____ Date of event _____ |   |
| <input type="checkbox"/> Other Coverage Elected<br>Date other coverage elected _____ |   |   |

Effective Date of Change: \_\_\_\_\_

Employer's Authorized Signature and Title \_\_\_\_\_ Date \_\_\_\_\_

WHITE - PHSIC      YELLOW - EMPLOYER'S COPY      PINK - EMPLOYEE COPY