

PREFERRED PLUS OF KANSAS, INC. ("PPK")

CHANGE/TERM FORM

P.O. Box 49288 • Wichita, KS 67201-9288 • (316) 609-2390 • Outside Sedgwick Co. 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
- Address Change - 1, 4
- Change Primary Care Physician - 1, 3
- Add Dependent Spouse - 1, 4, 5, 6
- Add Dependent Child(ren) - 1, 4, 5, 6 (Please list address if different than employees)
- Terminate Dependent Spouse - 1, 4, 5,
- Terminate Dependent Child(ren) - 1, 4, 5,
- Terminate All Coverage - 1

Employer Name / Group Number _____

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

6. 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 Contract, subject to PPK's approval of the change. In the event PPK 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 PPK, 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 BY EMPLOYER

Reason for Change/Termination

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

Effective Date of Change: _____

Employer Signature _____ Date _____