



P.O. Box 259710  
 Madison, WI 53725-9710  
 800.245.0533 Fax 608.273.1893

**MISCELLANEOUS  
 CHANGE FORM**

Employer Name <b>Iowa County</b>	Group No. 1330
Employee Name	Social Security Number

Reason for Change (check appropriate boxes)	Date of Change
<input type="checkbox"/> Marriage	
<input type="checkbox"/> Birth/Adoption	
<input type="checkbox"/> Loss of Other Insurance Coverage	
<input type="checkbox"/> Termination	
<input type="checkbox"/> Change of Name	
<input type="checkbox"/> Change of Address	

Type of Change Requested

Name Change From:	To:
Address Change From:	To:

Change Coverage:	Medical	Dental	Vision	Disability	Life
Single	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Add Dependents(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delete Dependent(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dependents to be Added			
Reason:			
Date of Event:			
Name	Sex	Date of Birth	Relationship

Are you financially responsible for all dependents listed above?  Yes  No  
 Are any of your dependents covered by another medical plan?  Yes  No

Name of Company	Policy, Group Number	Phone Number
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Is any child to be covered over age 19?  Yes  No If yes, provide full-time student verification, if required by your Plan.

If you had prior coverage which should apply to any pre-existing limitations under this Plan, please provide a Certificate of Prior Creditable Coverage (COPCC) documenting that coverage. If no COPCC is provided, it will be assumed that there is no applicable prior creditable coverage.

*I hereby attest that the information shown above is accurate to the best of my knowledge. If the change I have requested requires any additional premium contribution, I hereby authorize my employer to make the appropriate deductions from my salary. I also understand that if I have waived coverage for myself or any eligible dependent, special enrollment requirements may apply if I/we later wish to enroll.*

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