PBA
Professional Benefit Administrators, Inc.
900 Jorie Blvd Suite 250, Oakbrook, IL 60523 (800) 435-5694

ELIGIBILITY CHANGE FORM

EMPLOYER INFORMATION

Employer (Group) Name: City of Lake Forest | Group #: 010102 | Div #:

☐ Timely ☐ Special ☐ Late ☐ Court Ordered Dependent Coverage (Attach copy of order)

EMPLOYEE INFORMATION

Last Name | First Name | Middle Initial | Date of Birth | ID#

☐ **CHANGE INFORMATION**

Current Coverage:

☐ Single ☐ Medical ☐ Dental ☐ Vision
☐ Family ☐ Medical ☐ Dental ☐ Vision
☐ Medical Plan: ☐ Traditional Medical ☐ Employee Choice Medical ☐ Basic Medical
☐ Division #: _____

New Coverage:

☐ Single ☐ Medical ☐ Dental ☐ Vision
☐ Family ☐ Medical ☐ Dental ☐ Vision
☐ Medical Plan: ☐ Traditional Medical ☐ Employee Choice Medical ☐ Basic Medical
☐ Division #: _____
☐ Retirement Effective Date: _____

☐ **NAME CHANGE**

Previous Last Name | First Name | Initial

Reason: ☐ Marriage ☐ Divorce ☐ Other: | Effective Date:

☐ **ADDRESS CHANGE**

New Address (Street) | (City) | (State) | (Zip) | Phone #: _____
Effective Date:

☐ **DEPENDENT CHANGE**

Reason: ☐ Marriage ☐ Death of Spouse ☐ QMCSO ☐ Loss of Other Coverage ☐ Other (explain below)

Dependent(s) Affected: ☐ Spouse Only ☐ Spouse & Child(ren) ☐ Child(ren) Only

☐ Add
☐ Terminate

Last Name First Name	SSN	Relationship	Birthdate	Sex	Employed and Eligible for Other Coverage?
				M F	Y N
				M F	Y N
				M F	Y N
				M F	Y N

COORDINATION OF BENEFITS

Is your spouse employed and eligible for other insurance? ☐ No ☐ Yes

TYPE OF COVERAGE

☐ Medical	☐ Family	☐ Single
☐ Dental	☐ Family	☐ Single
☐ Vision	☐ Family	☐ Single
☐ Drug	☐ Family	☐ Single

Name Of Employer (Including address and telephone number)

Name of Other Insurance Company (Including address and telephone number)

Name of policyholder (Usually your spouse) | Policyholder's Identification Number | Account/Group Number | Eff Date

If you are adding an Adult Dependent, is he/she eligible for other coverage either through his/her own employer or that of his/her spouse (if married)? ☐ Yes ☐ No

If Yes, please list dependent name(s) and the name, address, phone number and group/plan number of the other insurance carrier(s):

_____

_____

Is anyone named on this notice eligible for Medicare coverage? ☐ No ☐ Yes Name of Person: _____	Reason ☐ Over 65 ☐ Disabled	Part A (Hosp.) Effective Date	Part B (Med.) Effective Date	Medicare Card #

☐ **TERMINATION**

Date Employment Terminated _____
Last Day of Coverage _____

☐ Single ☐ Medical ☐ Dental ☐ Vision ☐ All Coverages
☐ Family ☐ Medical ☐ Dental ☐ Vision ☐ All Coverages

VOLUNTARY TERMINATION OF COVERAGE REQUIRES EMPLOYEE'S SIGNATURE BELOW

EMPLOYEE SIGNATURE

Signature is required, except for termination of employment. By signing below you agree to be bound by the terms and conditions for yourself and your dependents. I understand that as an employee, I am required to provide the proper documentation, including birth certificates, marriage certificates, divorce decrees or student records to confirm my dependents proper coverage under these plans, if requested.

X _____ _____
Signature of Insured | Date Signed

EMPLOYER SIGNATURE

_____ | _____ | _____
Effective Date of Change | Signature of Employer | Date Signed

OFFICE USE ONLY

Initial / Date / Comments::