C2

Health Care Providers Group Insurance Plan
POLICY / COVERAGE CHANGE REQUEST

GREENSHIELD ID #: ____________________________

PLAN MEMBER NAME: ____

PART A— HEALTH CARE COVERAGE CHANGE

Current Coverage (check one)

PLAN 1 PLAN 1A PLAN 2 PLAN 65+
Complete / Optimum Level

Revised Coverage (check one)

PLAN 1 PLAN 1A PLAN 2 PLAN 65+
Essential Level

Coverage change to be effective the 1st day (month): ________________________
of Reason for coverage change: ____

PART B— DENTAL CARE COVERAGE CHANGE

Current Coverage (check one)

NO DENTAL BASIC DENTAL ENHANCED DENTAL

Revised Coverage (check one)

NO DENTAL BASIC DENTAL ENHANCED DENTAL

PART C — CORE COVERAGE CHANGE

ADD / INCREASE EMPLOYEE LONG TERM DISABILITY OR LIFE INSURANCE

Form #3 and #4 required. Please complete and submit in addition to this signed form.

ADD / INCREASE LIFE INSURANCE FOR A DEPENDENT SPOUSE OR CHILD

Form #3, #4, #5 and/or #6 required. Please complete and submit in addition to this signed form.

RELATION	FIRST NAME	LAST NAME	DATE OF BIRTH	GENDER

REMOVE COVERAGE **REDUCE COVERAGE**

Optional Employee Life Optional Spousal Life Optional Child Life Optional LTD

For coverage reduction, please reduce coverage to (new dollar amount) : $____________________

I authorize all changes requested above to be made to my account

SIGNATURE: ______________________________ DATE: ____________________

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