



Health Care Providers Group Insurance Plan POLICY / COVERAGE CHANGE REQUEST

C2

GREENSHIELD ID #: _____
PLAN MEMBER NAME: _____

PART A— HEALTH CARE COVERAGE CHANGE

	Current Coverage (check one)			
PLAN 1	PLAN 1A	PLAN 2		PLAN 65+ <i>Complete / Optimum Level</i>
	Revised Coverage (check one)			
PLAN 1	PLAN 1A	PLAN 2		PLAN 65+ <i>Essential Level</i>

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: _____