



REQUEST AND AUTHORIZATION FOR CHANGE

Employer Name: _____
 Client/Group #: _____
 Employee Name: _____
 Employee ID #: _____

Requested effective date of change _____

Please Check and Complete Applicable Items Below

Name Change: FROM _____ TO _____

Reason for Change: _____

Address Change: TO _____ (mailing address)
 _____ (city, state, zip)
 _____ (phone)

Beneficiary Change:
 (Required) Employee Signature: _____ Date: _____
 Primary: _____ Relationship: _____
 Contingent: _____ Relationship: _____

Transfer of coverage: Family Single From ID #: _____ To ID #: _____

Member Group Change: From Group ID #: _____ To Group ID #: _____

Change Single to Dependent Coverage; please attach a DAKOTACARE Administrative Services, Inc. Employee Enrollment Application for dependents, except newborns.

Add Newborn Dependent(s): COMPLETE INFORMATION BELOW AND SUBMIT TO DAKOTACARE ADMINISTRATIVE SERVICES, INC., WITHIN **THIRTY (30) DAYS** AFTER BIRTH OR START OF ADOPTION BONDING PERIOD.

Name	Date Dependent Acquired	SSN (not required on newborn)	Gender (M or F)	Date of Birth	*Is the Dependent covered by any medical insurance, including Medicare, that will continue AFTER the proposed effective date with DAKOTACARE?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

***If yes**, a copy of the other insurance or Medicare card **MUST** be attached.

Client/Employer Signature _____ **Date** _____

PLEASE RETURN COMPLETED FORM TO:	DAKOTACARE Administrative Services, Inc.	Telephone: (605) 334-4000
	Enrollment Department	Toll Free: (800) 325-5598
	2600 West 49 th Street	Fax Number: (605) 274-3284
	Sioux Falls, SD 57105-6575	Email: enrollment@dakotacare.com

***SEE REVERSE SIDE FOR TERMINATION REQUESTS**



NOTICE OF QUALIFYING EVENT FORM TERMINATION FORM/COBRA NOTIFICATION FORM

Employer Name: _____ Client/Group Number: _____

Employee Name: _____ Employee ID Number: _____

Employee Address: _____ Employee Telephone #: _____

City/State/Zip Code: _____ Employee Date of Birth: _____

Terminate Coverage On: Employee/Family Spouse Only Dependent(s) Only

Date Coverage Began: _____ Last Date of Employment: _____

Last Date of Coverage: _____ COBRA Begin Date: _____

List Name(s) to be Terminated	Date of Birth	Social Security Number	Type of Benefit(s) to be Terminated (Check the box(es) that apply)
			<input type="checkbox"/> Medical <input type="checkbox"/> Life <input type="checkbox"/> LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> STD
			<input type="checkbox"/> Medical <input type="checkbox"/> Life <input type="checkbox"/> LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> STD
			<input type="checkbox"/> Medical <input type="checkbox"/> Life <input type="checkbox"/> LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> STD
			<input type="checkbox"/> Medical <input type="checkbox"/> Life <input type="checkbox"/> LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> STD
			<input type="checkbox"/> Medical <input type="checkbox"/> Life <input type="checkbox"/> LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> STD
			<input type="checkbox"/> Medical <input type="checkbox"/> Life <input type="checkbox"/> LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> STD
			<input type="checkbox"/> Medical <input type="checkbox"/> Life <input type="checkbox"/> LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> STD

REASON FOR THIS TERMINATION (MUST CHECK ONE/CHECK ALL THAT APPLY)

EMPLOYEE

- Involuntary loss of Employment
- Resignation
- Layoff
- Medical Leave of Absence
- Non-Medical Leave of Absence
- Strike
- Reduction in Hours
- Entitlement to Medicare
- Military Leave: Date of Activation Notice: _____
- Death: Date of Death: _____
- Other Explain: _____

DEPENDENT

- Death: Date of Death: _____
- Divorce or Legal Separation:
Date of Divorce/Legal Separation: _____
- Loss of Dependent Status
- Military Leave: Date of Activation Notice: _____
- Entitlement to Medicare
- Other Explain: _____

Client/Employer Signature: _____ Phone#: _____ Date: _____

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