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)
______________________________ (county)

❑ 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 Employee Enrollment Application for dependents, except newborns.

❑ Add Newborn Dependent(s): COMPLETE INFORMATION BELOW AND SUBMIT TO DAKOTACARE, 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?
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ 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 Enrollment Department 5300 S Broadband Lane Sioux Falls, SD 57108	Telephone: (605) 334-4000 Toll Free: (800) 325-5598 Fax Number: (605) 274-3284 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)
			❑ Medical ❑ Life ❑ LTD ❑ Dental ❑ Vision ❑ STD
			❑ Medical ❑ Life ❑ LTD ❑ Dental ❑ Vision ❑ STD
			❑ Medical ❑ Life ❑ LTD ❑ Dental ❑ Vision ❑ STD
			❑ Medical ❑ Life ❑ LTD ❑ Dental ❑ Vision ❑ STD
			❑ Medical ❑ Life ❑ LTD ❑ Dental ❑ Vision ❑ STD
			❑ Medical ❑ Life ❑ LTD ❑ Dental ❑ Vision ❑ STD
			❑ Medical ❑ Life ❑ LTD ❑ Dental ❑ Vision ❑ 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: Date of Decree of Divorce: ______________
❑ Legal Separation:
Date of Decree of Separate Maintenance: ________
*NOTE: DAKOTACARE must have written consent from both parties.

______________ ______________
Employee Signature Spouse Signature

❑ Loss of Dependent Status
❑ Military Leave: Date of Activation Notice: ________
❑ Entitlement to Medicare
❑ Other: Explain:

Client/Employer Signature: ______________ **Phone#:** ______________ **Date:** ______________

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