DAKOTACARE®

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 2600 West 49th Street P.O. Box 7406 Sioux Falls, SD 57117-7406	Telephone: (605) 334-4000 Toll Free: (800) 325-5598 Fax Number: (605) 274-3284 Email: enrollment@dakotacare.com

*SEE REVERSE SIDE FOR TERMINATION REQUESTS

DAKOTACARE®
THE HEALTH CARE PLAN OF THE SOUTH DAKOTA MEDICAL ASSOCIATION

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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