DAKOTACARE ADMINISTRATIVE SERVICES, INC.

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 Family or Single coverage ☐ F ☐ S 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?
					☐ 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 Administrative Services, Inc.
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 ADMINISTRATIVE SERVICES, INC.

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 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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