Preferred Health Plan of the Carolinas
"Health Coverage That Fits"
PO Box 220397, Charlotte, NC 28222
Toll Free: 866-636-0239

Request for Change of Name, Address, Beneficiary or Addition / Cancellation of Coverage

I hereby request the following changes in connection with my group insurance:

Employee Name (Please PRINT): _____
(Last) (First) (Middle Initial)

A. ☐ Change my name - From: _____
(Last) (First) (Middle Initial)

To: _____
(Last) (First) (Middle Initial)

Reason for Change: _____

B. ☐ Change my beneficiary – To: _____
(Last) (First) (Middle Initial)

Relationship to Employee: _____
By this request I revoke all prior beneficiary designations.

C. ☐ Add coverage for: ☐ Spouse only ☐ Child(ren) only ☐ Spouse and Child(ren)

D. ☐ Cancel coverage for: ☐ Employee only ☐ Child(ren) only ☐ Employee & all Dependents
☐ Spouse only ☐ Spouse and Child (ren)

Type of coverage added / cancelled:
☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Other _____

List persons adding / canceling coverage:
(The name, date of birth, social security number and the effective date of change of each person adding or canceling coverage must be listed)

	Last Name	First Name	MI	Sex	Date of Birth	Social Security Number	A=Add C=Cancel	Effective date of change
Employee				**M /F**	**/ /**		**A / C**	**/ /**
Spouse				**M /F**	**/ /**		**A / C**	**/ /**
Child				**M /F**	**/ /**		**A / C**	**/ /**
Child				**M /F**	**/ /**		**A / C**	**/ /**
Child				**M /F**	**/ /**		**A / C**	**/ /**
Child				**M /F**	**/ /**		**A / C**	**/ /**

Reason for change: _____

E. ☐ Certificate of Creditable Medical Coverage – Complete when adding coverage.

Do you or your dependents have previous creditable medical coverage under another health plan such as an employer sponsored group health plan or HMO, individual policy, Medicare, Medicaid or Campus? ☐ Yes ☐ No

If YES, a copy of any certificates of creditable medical coverage may be required prior to any claims being processed under this plan.
☐ Certificate attached ☐ Certificate being forwarded

F. ☐ Change my mailing address: _____
Street

_____
City State Zip Code

I understand that my election of coverages above does not automatically guarantee that coverage is in force. All eligibility requirements of the policy(ies) must be properly satisfied before coverage becomes effective.

_____ _____ _____
Signature of Employee (required *-except for termination of employment)* | Social Security Number | Name of Employer

_____ _____ _____
Witness | Date (*required)* | Division / Location