NEW HIRE ADDITION AND CHANGE REQUEST FORM

FORM MAY BE USED FOR MULTIPLE CHANGES (PLEASE PRINT)

PRODUCT INFORMATION (please indicate which product(s) applies):

☐ Supplemental Medical	☐ Critical Illness	☐ Limited Medical	☐ Short Duration Disability	☐ Short Term Disability	☐ AD&D

GROUP INFORMATION

Group Name:	**Group Policy #:**

CHANGE REQUEST (please check the change(s) being requested):

☐ EMPLOYEE /DEPENDENT TERMINATION:

Employee Name: _____

Date of Change: _____

Terminate:

☐ Employee and dependents

☐ Dependent(s) only:

Dependent(s) Name: _____

Note: If termination is a COBRA event:

COBRA start date _____ (MM/DD/YEAR)

COBRA eligibility end date _____ (MM/DD/YEAR)

Reason for Termination:

☐ Termed employment

☐ Attainment of age

☐ Death

☐ Change from Full Time to Part Time

☐ Retired

☐ Marriage of a dependent child

☐ Other (please explain):

_____

_____

☐ ADDITION OF A DEPENDENT:

Employee Name: _____

Dependent Name: _____

Add:

☐ Spouse Date of Birth: _____

☐ Child Gender: ☐ Male ☐ Female

Date: _____

(Date of marriage, or birth/adoption of dependent)

Reason for Addition:

☐ Birth ☐ Adoption

☐ Marriage ☐ Divorce

☐ Loss of Coverage

☐ Adding over-age dependent, due to mental disability

(Please provide physician statement.)

☐ Qualified Medical Child Support Order (QMCSO)

(Please attach court order.)

☐ EMPLOYEE NAME CHANGE:

Current Name: _____

Change to: _____

Reason for Change: _____

☐ EMPLOYEE ADDRESS CHANGE:

Employee Name: _____

New Address: _____

(Include street, city, state and zip)

☐ EMPLOYEE CHANGE IN PAY LOCATION (if change applies to more than one employee, please attach list):

Employee Name: _____

Old Pay Location: _____ New Pay Location: _____

EMPLOYER VERIFICATION

Employer Name:	**Employer Title:**
Employer Signature:	**Date:**

Submit by Fax: (877) 239-7735, OR Scan/Email: beazleyprocessing@beazleybenefits.com, OR Mail: PO Box 30103, Tampa FL 33630-3103.

For AD&D, please submit a signed copy of the enrollment form to Beazley. For all products, retain a signed copy of the enrollment form for your records.

NEW HIRE ADDITION AND CHANGE REQUEST FORM

FORM MAY BE USED FOR MULTIPLE NEW HIRES (PLEASE PRINT)

PRODUCT INFORMATION (please indicate which product(s) applies):

☐ Supplemental Medical	☐ Critical Illness	☐ Limited Medical	☐ Short Duration Disability	☐ Short Term Disability	☐ AD&D

GROUP INFORMATION

Group Name:	**Group Policy #:**

NEW HIRE ADDITION (please check the coverage(s) being requested):

☐ ADDITION OF A NEW EMPLOYEE:

Employee Name: _____

Date of Birth: _____

Social Security #: _____

Address: _____
(Include street, city, state and zip)

Date of Hire: _____ Pay Location: _____

Add Coverage for:
☐ Employee only ☐ Employee and dependents

Name: _____ DOB: _____
☐ Spouse ☐ Child Gender: ☐ Male ☐ Female

Name: _____ DOB: _____
☐ Spouse ☐ Child Gender: ☐ Male ☐ Female

Name: _____ DOB: _____
☐ Spouse ☐ Child Gender: ☐ Male ☐ Female

Name: _____ DOB: _____
☐ Spouse ☐ Child Gender: ☐ Male ☐ Female

☐ ADDITION OF A NEW EMPLOYEE:

Employee Name: _____

Date of Birth: _____

Social Security #: _____

Address: _____
(Include street, city, state and zip)

Date of Hire: _____

Pay Location: _____

Add Coverage for:
☐ Employee only ☐ Employee and dependents

Name: _____ DOB: _____
☐ Spouse ☐ Child Gender: ☐ Male ☐ Female

Name: _____ DOB: _____
☐ Spouse ☐ Child Gender: ☐ Male ☐ Female

Name: _____ DOB: _____
☐ Spouse ☐ Child Gender: ☐ Male ☐ Female

Name: _____ DOB: _____
☐ Spouse ☐ Child Gender: ☐ Male ☐ Female

☐ ADDITION OF A NEW EMPLOYEE:

Employee Name: _____

Date of Birth: _____

Social Security #: _____

Address: _____
(Include street, city, state and zip)

Date of Hire: _____ Pay Location: _____

Add Coverage for:
☐ Employee only ☐ Employee and dependents

Name: _____ DOB: _____
☐ Spouse ☐ Child Gender: ☐ Male ☐ Female

Name: _____ DOB: _____
☐ Spouse ☐ Child Gender: ☐ Male ☐ Female

Name: _____ DOB: _____
☐ Spouse ☐ Child Gender: ☐ Male ☐ Female

Name: _____ DOB: _____
☐ Spouse ☐ Child Gender: ☐ Male ☐ Female

EMPLOYER VERIFICATION

Employer Name:	**Employer Title:**
Employer Signature:	**Date:**

Submit by Fax: (877) 239-7735, OR Scan/Email: beazleyprocessing@beazleybenefits.com, OR Mail: PO Box 30103, Tampa FL 33630-3103

For AD&D, please submit a signed copy of the enrollment form to Beazley. For all products, retain a signed copy of the enrollment form for your records.