ENROLLMENT CHANGE FORM

SECURITY REMINDER: IF YOU HAVEN'T ALREADY DONE SO, PLEASE REGISTER AT THE ENTRUST SECURE MESSAGE CENTER SO ALL DOCUMENTS SENT BY YOU WILL REMAIN SECURE
HTTP://WEB1.ZIXMAIL.NET/S/WELCOME.JSP?B=ENTRUSTINC
SCAN, FAX, EMAIL OR SEND A COPY TO:
ENTRUST, INC. – MEMBER SERVICES TEAM – ADMIN@ENTRUSTINC.COM
22322 GRAND CORNER DRIVE SUITE #200 KATY, TEXAS 77494
PHONE: (281) 368-7878 OR TOLL FREE (800) 436-8787 FAX: (281) 809-6780

INTERNAL USE ONLY
ENCORE: ☐ EASI: ☐
PROCESS DATE: _____
DATE RECEIVED: _____
INITIALS: _____

THIS SECTION MUST BE COMPLETED

GENERAL INFORMATION

NAME OF EMPLOYER PLAN SPONSOR:
GROUP NUMBER:
LOCATION/SUB-GROUP: (IF APPLICABLE):
EMPLOYEE NAME: (PRINT) LAST, FIRST, MI:
SOCIAL SECURITY NUMBER:

CHANGE INFORMATION

CHANGE EFFECTIVE:
☐ **PLAN CHOICE CHANGE: FROM PLAN _____ TO PLAN _____**
☐ **REASON FOR CHANGE:**
☐ **TERMINATE MY PERSONAL COVERAGE. REASON:**
CHANGE IS FOR (CHECK ALL THAT APPLY): ☐ **MEDICAL,** ☐ **DENTAL,** ☐ **VISION,** ☐ **LIFE, STD/LTD**

OTHER – MAKE THE CHANGES AS INDICATED BELOW

NAME/ADDRESS/PHONE NUMBER/BENEFICIARY CHANGES

CHANGE MY NAME: FROM:		**TO:**	
REASON FOR NAME CHANGE:			
CHANGE OF ADDRESS (NEW ADDRESS):			
CHANGE OF PHONE NUMBER (NEW PHONE NUMBER):			
CHANGE OF BENEFICIARY: I HEREBY REVOKE ALL PRIOR BENEFICIARY DESIGNATIONS AND DESIRE THE FOLLOWING:			
PRIMARY BENEFICIARY (COMPLETE BELOW)			
FULL NAME	**SOCIAL SECURITY NUMBER**	**RELATIONSHIP**	**PERCENTAGE**
CONTINGENT BENEFICIARY (COMPLETE BELOW)			
FULL NAME	**SOCIAL SECURITY NUMBER**	**RELATIONSHIP**	**PERCENTAGE**

PLEASE PRINT CLEARLY BELOW

DEPENDENT COVERAGE CHANGE (INCLUDING SPOUSE)

☐ **ADD OR** ☐ **DELETE ELIGIBLE DEPENDENTS**

	DEPENDENT 1	**DEPENDENT 2**	**DEPENDENT 3**
LAST NAME, FIRST NAME, MI			
GENDER:			
DOB:			
SSN:			
RELATIONSHIP:			
CHANGE REASON:			
EFFECTIVE DATE:			

OTHER COVERAGE INFORMATION

IF ADDING DEPENDENTS, DOES ANYONE CURRENTLY HAVE OTHER COVERAGE: ☐ **YES OR** ☐ **NO**

IF YOU ANSWERED YES TO THE ABOVE QUESTION, PLEASE PROVIDE A COPY (FRONT & BACK) OF YOU OTHER INSURANCE CARD(S)

***HIPAA NOTICE**: IF YOU ARE DECLINING ENROLLMENT FOR YOURSELF OR YOUR DEPENDENTS (INCLUDING YOUR SPOUSE) BECAUSE OF OTHER HEALTH INSURANCE OR GROUP HEALTH PLAN COVERAGES, YOU MAY BE ABLE TO ENROLL YOURSELF AND YOUR DEPENDENTS IN THIS PLAN IF YOU OR YOUR DEPENDENTS LOSE ELIGIBILITY FOR THAT OTHER COVERAGE (OR IF THE EMPLOYER STOPS CONTRIBUTING TOWARDS YOUR OR YOUR DEPENDENTS' OTHER COVERAGE). HOWEVER, YOU MUST REQUEST ENROLLMENT WITHIN 31 DAYS AFTER YOUR OR YOUR DEPENDENTS' OTHER COVERAGE ENDS (OR AFTER THE EMPLOYER STOPS CONTRIBUTING TO YOUR COST OF COVERAGE). IN ADDITION, IF YOU HAVE A NEW DEPENDENT AS A RESULT OF MARRIAGE, BIRTH, ADOPTION, OR PLACEMENT OF ADOPTION, YOU MAY BE ABLE TO ENROLL YOURSELF AND YOUR DEPENDENTS. HOWEVER, YOU **MUST** REQUEST ENROLLMENT IN WRITING WITHIN 31 DAYS AFTER THE MARRIAGE, BIRTH, ADOPTION, OR PLACEMENT OF ADOPTION. TO REQUEST SPECIAL ENROLLMENT OR OBTAIN MORE INFORMATION, REFER TO YOUR SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT OR CONTACT YOUR EMPLOYER.*

I UNDERSTAND ANY INTENTIONAL MATERIAL FALSE STATEMENT, MISREPRESENTATION OR OMISSION ON THIS FORM WHICH CHANGES THE RISK ASSUMED BY THIS PLAN MAY CAUSE LOSS OF COVERAGE UNDER THIS PLAN AND MAY RESULT IN AN INCREASE IN PREMIUM. I HEREBY ENROLL OR DIS-ENROLL FOR BENEFITS FOR WHICH I AM PRESENTLY ELIGIBLE, OR WHICH I MAY BECOME ELIGIBLE, UNDER MY EMPLOYER'S GROUP CONTRACT. IF ANY DEDUCTIONS ARE REQUIRED FOR THIS COVERAGE, I AUTHORIZE SUCH DEDUCTIONS FROM MY EARNINGS.

EMPLOYEE SIGNATURE:	**DATE:**
EMPLOYER / HR ADMINISTER INITIALS:	**DATE:**