



CHANGE OF MEMBERSHIP STATUS

CURRENT INFORMATION:

Employee Name: _____
(Last, First, Middle)

Address: _____
Street City State Zip

Social Security No.: ____ - ____ - ____ Type of Coverage: _____ Single: ____ Family: ____

NEW INFORMATION:

EFFECTIVE DATE OF CHANGE: _____

Name: _____

Address: _____

Type of Coverage Desired: _____ Single: ____ Family: ____

Addition/deletion of dependent:

CHECK ONE			Full Name	Sex (M/F)	Birthdate	Relationship
Change	Add	Delete				

Changes in Coverage:

Effective Date:

Left Employment _____
Deceased _____
Waived by Employee _____
Changed to Part Time _____

____/____/____
____/____/____
____/____/____

Please read the following and place your signature in the space provided.

I hereby apply for amendment of my application to North Star Health. It is mutually agreed that these changes shall not become effective unless this application is accepted. As stated in my summary plan description, the effective date of such change shall coincide with the 1st of the month, following the date of the benefit or classification change. Changes due to termination will be effective the last day of the month. This application for change will become part of my original application and will be subject to terms and agreement in effect. Group changes due to employment termination will be effective the 1st of each calendar year.

Employee Signature

Date

FOR EMPLOYER ONLY

Employer: Please return the completed form to the above address:

Company Name

Approval Signature