GreenTree ADMINISTRATORS

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RECORD CHANGE CARD

- For Adjustments Only-

20061213

NAME OF EMPLOYER:	DATE OF BIRTH:
PARTICIPANT'S (LAST NAME) (FIRST NAME) (MIDDLE INITIAL)	**SEX:** MALE ☐ FEMALE ☐

MARITAL STATUS	DEPENDENTS ELIGIBLE FOR COVERAGE
☐ SINGLE ☐ MARRIED ☐ WIDOWED	☐ NONE ☐ SPOUSE ☐ CHILD(REN) (INICATE NO.) _____
☐ DIVORCED ☐ LEGALLY SEPARATED	☐ OTHER DEPENDENT (RELATIONSHIP) _____

REASON FOR REQUEST FOR ADJUSTMENT

* 1. ☐ ADD DEPENDENT COVERAGE: ☐ WIFE ☐ HUSBAND ☐ CHILD

A. IF ADDING SPOUSE, GIVE DATE OF MARRIAGE: _____

B. IF ADDING NEWBORN CHILD, GIVE DATE OF BIRTH: _____

C. IF ADDING OTHER CHILDREN, GIVE REASON AND DATE ACQUIRED: _____

*2. ☐ TERMINATE DEPENDENT COVERAGE ONLY. GIVE DATE _____

REASON: ☐ MARRIED ☐ DIVORCE ☐ DECEASED ☐ OTHER _____

***LIST BELOW NAME(S) OF DEPENDENTS(S) FOR COVERAGE TO BE ADDED OR TERMINATED.**

*********NOTE*********

If adding any dependents due to special enrollment, please send certificate of creditable coverage (COCC)

If spouse is employed, please provide employer information below.

If dependent is a Full Time Student, please provide proof of credited hours.

DEPENDENT FULL NAME (LAST, FIRST, MIDDLE)	SEX	DATE OF BIRTH	SSN	RELATION-SHIP	OTHER	EFFECTIVE DATE GTA ONLY
(Spouse)					Employed Yes / No	
					Full Time Student Yes / No	
					Full Time Student Yes / No	
					Full Time Student Yes / No	
					Full Time Student Yes / No	

Other Coverage Information

Spouse Employer Information:	Employer Name:	Employer Address:	Phone:

Dependent Name	Other Health Plan Carrier	Carrier Address	Policy # / Group #	Insured / Policyholder Name:	Insured/Policyholder SSN

3. ☐ CHANGE CLASS FROM _____ TO _____

4. ☐ NAME CHANGE _____ (OLD NAME) TO _____ (NEW NAME)

5. ☐ NEW ADDRESS _____ (STREET ADDRESS) (CITY) (STATE) (ZIP)

(LAST NAME)	FIRST NAME)	(MIDDLE)	RELATIONSHIP	DATE OF BIRTH		
				MONTH	DAY	YEAR

PARTICIPANT'S SIGNATURE _____ MEMBER ID _____ DATE SIGNED _____