REQUEST FOR ENROLLMENT CHANGE FORM

Group Name_____ Group Number: _____Division:_____ Effective Date of Change: _____

Indicate Type of Change Below ↓

☐ NAME – If your name has changed, please indicate YOUR PRIOR name so we can correctly identify you: _____
(NAME WAS)

☐ ADD DEPENDENT ☐ DROP COVERAGE (complete waiver on back) ☐ DROP DEPENDENT (complete waiver on back)

☐ CHANGE BENEFICIARY ☐ NAME CHANGE ☐ ADDRESS CHANGE ☐ PLAN CHANGE _____ (NEW)

IF WAIVING OR DROPPING COVERAGE, PLEASE COMPLETE WAIVER SECTION ON BACK.

EMPLOYEE INFORMATION (REQUIRED):

Employee Last Name	Employee First Name		Social Security Number	
Address	**City**	**State**	**Zip**	**Telephone**

CHANGE MY BENEFICIARY (for plans with life insurance) attach a separate sheet, if necessary:

Last Name, First Name	Relationship	Date of Birth	Complete Address / Phone Number

COVERAGE: ☐ MEDICAL ☐ DENTAL ☐ VISION

CHANGE MY ENROLLMENT AS INDICATED BELOW (PLEASE COMPLETE ENTIRE SECTION):

Last Name, First Name, Initial	Sex	Social Security Number	Date of Birth	Relationship	Medical Coverage Y or N	Dental Coverage Y or N	Vision Coverage Y or N

Any children listed above must be either: 1.) your natural child or your legally adopted child **or** 2.) your stepchild or any other child who meets the definition of a dependent as defined in the TPM Summary Plan Document.

REASON FOR ADD/CHANGE (indicate below)	DATE OF EVENT			REASON FOR DROP (indicate below)	DATE OF EVENT		
Newborn DOB				**Over Age 26 dependent child**			
Adoption (attach proof)				**Divorce or Legal Separation (circle one)**			
Marriage (date of Marriage required)				**In Anticipation of Divorce**			
Other: _____				**Ineligible Dependent**			
Medical Support Notice Order (attach proof)				**Reason: _____**			
Loss of Other Coverage:				**Waiving Coverage: (You must complete the wavier on the back of this form for every covered person, including the reason.)**			

Other Insurance Information & Creditable Coverage Information Required:

Do you or your enrolled family members have any OTHER coverage that you will keep in addition to this coverage? ___YES___ NO
*** IF YES**, please give name of each person covered, the other Plan Name, Address and Phone Number: _____
Please include a copy of your Certificate of Creditable Coverage from your prior employer/carrier showing the effective date and termination date, if applicable. *

I UNDERSTAND that providing inaccurate or incorrect information to any of the questions on this Enrollment Form may be considered health care fraud.

_____ _____

Employee Signature (required) **Date** (required)

2020

HEALTH COVERAGE WAIVER FORM

(Complete Waiver only if you are waiving coverage for yourself and / or any dependent)

GROUP / EMPLOYER NAME:	**GROUP NUMBER**
EMPLOYEE NAME: (LAST) (FIRST) (INITIAL)	**SOCIAL SECURITY NUMBER**

I decline to enroll in health coverage for:

☐ Myself ☐ My Spouse Reason for waiver: ☐ the existence of other coverage

☐ My Dependent Child/Children (please list) ☐ other reason (explain)_____

1._____ 2._____

3._____ 4._____

5._____ 6._____

I understand that this waiver of coverage may affect the ability of each person listed above to obtain coverage at a later date. Specifically, except during applicable "Special Enrollment Periods," each person listed above may be considered to be a Late Enrollee, and will be required to wait until the Group's next annual open enrollment period.

EMPLOYEE'S SIGNATURE _____ DATE SIGNED _____

SPOUSE'S SIGNATURE _____ DATE SIGNED _____
(If Spouse is waiving coverage)

TPM TRUST

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