Kelly Benefits

EXISTING MEMBER TERMINATION / CHANGE FORM

Please print clearly in CAPITAL letters | Please fill in the circles completely ●

GENERAL INFORMATION

1

Company Name			Kelly Benefits Company ID#
Last Name	First Name	MI	Suffix (Jr., III, etc.)
Social Security#	Date of Birth	Employer Phone	

EMPLOYEE TERMINATION OF COVERAGE

2

☐ **Terminate ALL Active Lines of Coverage**

Terminate Only: ☐ Health ☐ Vision ☐ Vol. Life ☐ Vol. Sp. Life ☐ STD ☐ LTD ☐ Suppl. Life/AD&D ☐ Dental ☐ Life/AD&D ☐ Vol. AD&D ☐ Vol. Dep. Life ☐ Vol. STD ☐ Vol. LTD

Reason for Termination:

☐ Employment Status Change ☐ Death of Employee ☐ Loss of Dependent Status ☐ Non-Payment of COBRA Premium

☐ End of Employment - INVOLUNTARY ☐ Enrollment in Medicare ☐ Dropping Coverage Voluntarily ☐ Gain of Other Coverage

☐ End of Employment - VOLUNTARY ☐ Reduction in Hours ☐ Court Ordered Cancellation ☐ Not Eligible ☐ *Other:*

Qualifying Event Date:

Coverage Term Date:

CHANGE IN CURRENT COVERAGE LEVEL

3

MEDICAL ONLY		DENTAL ONLY		VISION ONLY		ALL LINES		OTHER Plan _____	
FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
☐ Employee Only	☐	☐ Employee Only	☐	☐ Employee Only	☐	☐ Employee Only	☐	☐ Employee Only	☐
☐ Employee & Child(ren)	☐	☐ Employee & Child(ren)	☐	☐ Employee & Child(ren)	☐	☐ Employee & Child(ren)	☐	☐ Employee & Child(ren)	☐
☐ Employee & Spouse	☐	☐ Employee & Spouse	☐	☐ Employee & Spouse	☐	☐ Employee & Spouse	☐	☐ Employee & Spouse	☐
☐ Family	☐	☐ Family	☐	☐ Family	☐	☐ Family	☐	☐ Family	☐

Qualifying Event: ☐ Marriage ☐ Newborn / Adoption ☐ Loss of Coverage **Qualifying Event Date:** **Requested Date of Change:**

Last, First, MI	Social Security #	Birth Date	Sex (M/F)	F/T Student (Y/N)*	Disabled (Y/N)	PCP Info (where required)		Existing Patient (Y/N)
						Physician Name	Physician #	
Spouse								
Child								
Child								
Child								

Are you or any of your dependents eligible for Medicare? If Yes: Effective Date (Part A): Effective Date (Part B):

MISCELLANEOUS CHANGES

4

Name Change : From: _____ To: _____

Address Change: From: _____ To: _____

_____ _____

Telephone Number Change: From: ( ) _____ To: ( ) _____

Salary Change: From: $ _____ To: $ _____ Effective Date of Change: ___/___/___

Provider Change: ☐ PCP ☐ OB/GYN ☐ DENTIST Change for all members?: ☐ Y ☐ N If no, list member name: _____

From: _____ # _____ To: _____ # _____ Existing Patient: ☐ Y ☐ N

Medicare: ☐ Add ☐ Drop

Name: _____ Medicare ID #: _____ Part A: ___/___/___ Part B: ___/___/___

Beneficiary Change- Life Insurance: I am changing my group term Life Insurance beneficiary(s) (Please print full name including middle initial)

Primary To: _____ Relationship: _____ Percentage: _____

Secondary To: _____ Relationship: _____ Percentage: _____

5

EMPLOYEE SIGNATURE _____ **DATE** _____

EMPLOYER SIGNATURE / VERIFICATION _____ **DATE** _____

Note: Form invalid without required signatures

Notice to the Insured:

The insurance carrier sells insurance products pursuant to which eligible employees of the policyholder may obtain coverage. Kelly & Associates Insurance Group, Inc. actively administers the insurance carrier's health insurance program. Premiums are made by the policyholder to Kelly Benefits on behalf of eligible employees. These amounts are forwarded to the insurance carrier that provides the benefits for the eligible employees. Kelly Benefits is authorized by the insurance carrier to perform the following functions for group health benefit plans and all other insurance products issued, administered, or marketed by the insurer: process enrollment activity, collect premiums, and remit payments to the carrier; and answer questions pertaining to enrollment activity, invoice, or benefit inquiries.

Notice of Nondiscrimination and Accessibility:

Kelly Benefits complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kelly Benefits does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Kelly Benefits:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Kelly Benefits Corporate Compliance (compliancegroup@kellybenefits.com).

If you believe that Kelly Benefits has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Kelly Benefits Corporate Compliance, 1 Kelly Way, Sparks, MD 21152, compliancegroup@kellybenefits.com, telephone (443) 589-1980.

You can file a grievance in person or by mail, or email. If you need help filing a grievance, Kelly Benefits Corporate Compliance (compliancegroup@kellybenefits.com) is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-804-0486.
繁體中文 (Chinese)
注意:如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-804-0486。
한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855-804-0486 번으로 전화해 주십시오.
Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 855-804-0486.
Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 855-804-0486.
Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 855-804-0486.
Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 855-804-0486.
አማርኛ (Amharic)
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 855-804-0486.
Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ (Bassa)
Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá 855-804-0486.
Igbo asusu (Ibo)
Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 855-804-0486.
èdè Yorùbá (Yoruba)
AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 855-804-0486.
) اُردُوUrdu)
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کیخدمات مفت میں دستیاب ہیں ۔ کال کریں 855-804-0486 .
) فارسیFarsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-804-0486 تماس بگیرید.
Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 855-804-0486.
Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 855-804-0486.