ASSURANT Health

Certificate Change Form

Group No. _____ Group Name _____
Requesters Telephone No. _____ Fax No. _____ Request Date _____
Number of pages including cover page_____

Administration – Fax all Administration changes to (414) 299-8906 or 414-299-8493

Please note if you have a salary change that is 15% or **less**, fill in the information in this table. If the salary change is 15% or higher, underwriting must approve this change.

		Termination		Salary Change		
Cert No.	Employee Name	Reason Code	Effective Date	Effective Date	New Salary Amount	
					$	per
					$	per
					$	per
					$	per
					$	per
					$	per

Reason code: 1–Terminated Employment 2–Laid Off 3–No longer Eligible
4–Remove Medical Only 5-Remove Dental Only 6-Other – *(Please provide details)*

__ Terminate child and/or spouse Effective date _____ Name_____
You may report terminations by phone at 1-(800)-444-6254, Option #2, Option #2

__ Beneficiary Change
(Attach beneficiary change form # 19201)

__ Change to existing certificates
(SSN, Name, Address, etc., Please indicate employer certificate number and change request in the message section below)

__ Other *(Please provide details in the message section below)*

__ State/Federal COBRA continuation
(Attach continuation form # U2888)

__ Plan Changes*(Attach signed copy of quote)*

__ Group Street Address Change *(Write new address in message section below)*

__ Group Mailing Address Change *(Write new address in message section below)*

Message_____

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Underwriting – Fax all Underwriting requests to (414) 299-1061

Salary increases of 15% or higher will require a **complete Employee Enrollment Form**. This will require underwriting approval.

__ Adding spouse* *(Attach completed enrollment application)*†
__ Newborn child* *(Attach completed enrollment application)*†

To avoid lengthier pre-existing periods and/or gaps in coverage, it is recommended that spouses and newborns be added to the group within 31 days of the date of marriage or birth.

__ Add child(ren) *(Attach completed enrollment application)*†
__ New employee *(Attach completed enrollment application)*†
__ Increase/adding line of coverage for group *(Attach completed enrollment application)*
__ Add coverage on an employee *(Attach completed enrollment application and quote)*
__ Other *(Please provide details in the message section below)*

† *Please refer to your New Business Kit for Employee Enrollment Forms.*

Message_____

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