

Administration Department
 Polaris Benefits Administrators
 P.O. Box 2010
 Westerville, OH 43086
 800.234.0225

CHANGE FORM

EMPLOYER: ESC of Central Ohio Group # PBA 00145 Location # _____

EMPLOYEE'S NAME _____ SOCIAL SECURITY # _____

TYPE OF NOTICE: TERMINATION CHANGE CORRECTION

EFFECTIVE DATE OF CHANGE _____

MEDICAL ONLY DENTAL ONLY MEDICAL AND DENTAL

Please terminate all coverages on the above date.

Change name from: _____ to _____

Change address to: _____

Change division to: _____

Change earnings to: _____

Change beneficiary to: _____

(Full name and relationship)

Addition and deletion of dependents:

ADD If dependent being added had prior coverage please include Certificate of Creditable Coverages (HIPPA). Do dependents being added currently have medical coverage they are continuing? YES NO

DELETE

Name of Dependent	Social Security #	Date of Birth	Reason for Change	Prior Coverage	
				YES	NO
				YES	NO
				YES	NO
				YES	NO

Employee Request and Signature:

I request that the above changes be made and authorize any payroll deductions if required for the above.

EMPLOYEE: _____ DATE: _____

EMPLOYER: _____ DATE: _____