

APPLICATION FOR CHANGE IN GROUP AGREEMENT



INTER-COUNTY HOSPITALIZATION PLAN, INC.
INTER-COUNTY HEALTH PLAN, INC.
 720 Blair Mill Road Horsham, PA 19044
 Subscriber Service (215) 657-8900
 Toll Free in Pennsylvania 1-800-492-2385

Please type or print all information firmly.
 You are making copies. Incomplete or illegible information will delay your change.

Employee's Last Name, First Name, M.I.	Group/Company/Division Name	Group #	Agreement #
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Home Phone Number () _____ email address _____

Make the following changes to my Agreement effective ____/____/____ (Month/Day/Year)

SIGNATURE AND DATE, ALWAYS REQUIRED—My signature confirms that I have read and understand the information on the back of this form and request the action indicated below. I understand that the change date required will be effective provided that it is in accordance with the terms of the group contract.

Employee's Signature: _____ Date: _____

1. **NAME CHANGE**—From: _____ To: _____

2. **ADD DEPENDENTS** — Enroll the dependents listed below in my Agreement. (Eligible dependents are the employee's spouse and unmarried children under age 19, unless the child is a fulltime student.)

First Name, Middle Initial (Last Name if different from Employee's)	Relation	Birthdate	Sex	Social Security #	Medicare or RR Retiree ID #	Fulltime student? *

* Attach completed Student Verification Form for each unmarried child, age 19 or over, who is a fulltime student in an accredited school.

REASON FOR ADDITION (For spouse, include Marriage Date.

For adopted child, include a copy of adoption papers.): _____

OTHER COVERAGE INFORMATION (Complete when adding dependents to your Agreement.)

Place a check next to all who are now covered by other Group Health Insurance, including other Inter-County:

Me
 My spouse
 My dependent children
 None

Name of Insurance Carrier	Name of Group	Coverage Issued to:	Effective Date	Spouse's Birthdate
		<input type="checkbox"/> Me <input type="checkbox"/> My spouse <input type="checkbox"/> Other	/ /	/ /

3. **CHANGE MY HOME ADDRESS TO:** _____ City _____ State _____ Zip Code _____

4. **CANCEL ENTIRE AGREEMENT.** Reason for cancellation: _____

5. **CANCEL BENEFITS FOR THE ENROLLED DEPENDENTS LISTED BELOW.**
 DECLINE BENEFITS FOR THE NEWLY ELIGIBLE DEPENDENTS LISTED BELOW.

—OR—

First Name, Middle Initial (Last Name if different from Employee's)	Relation	Birthdate	Sex	Reason for Cancellation or Declination