PBA
Professional Benefit Administrators, Inc.
900 Jorie Blvd Suite 250, Oakbrook, IL 60523 (800) 435-5694

ELIGIBILITY CHANGE FORM

EMPLOYER INFORMATION
Employer (Group) Name: City of Lake Forest
Group #: 010102
☐ Timely ☐ Special ☐ Late ☐ Court Ordered Dependent Coverage (Attach copy of order)

EMPLOYEE INFORMATION
Last Name | First Name | Middle Initial | Date of Birth | ID#

☐ **CHANGE INFORMATION**

Current Coverage:
☐ Single ☐ Medical ☐ Dental ☐ Vision
☐ Family ☐ Medical ☐ Dental ☐ Vision
☐ Employee Choice Medical ☐ HSA Basic

New Coverage:
☐ Single ☐ Medical ☐ Dental ☐ Vision
☐ Family ☐ Medical ☐ Dental ☐ Vision
☐ Employee Choice Medical ☐ HSA Basic
☐ Retirement Effective Date: ____________________________________

☐ **NAME CHANGE**
Previous Last Name | First Name | Initial
Reason: ☐ Marriage ☐ Divorce ☐ Other: Effective Date:

☐ **ADDRESS CHANGE**
New Address (Street) (City) (State) (Zip) Phone #: ____________________________
Effective Date:

☐ **DEPENDENT CHANGE**
Reason: ☐ Marriage ☐ Death of Spouse ☐ QMCSO ☐ Loss of Other Coverage ☐ Other (explain below)
Dependent(s) Affected: ☐ Spouse Only ☐ Spouse & Child(ren) ☐ Child(ren) Only
☐ Add
☐ Terminate

Last Name First Name	SSN	Relationship	Birthdate	Sex	Employed and Eligible for Other Coverage?
				☐M ☐F	☐ Y ☐ N
				☐M ☐F	☐ Y ☐ N
				☐M ☐F	☐ Y ☐ N
				☐M ☐F	☐ Y ☐ N

COORDINATION OF BENEFITS

Is your spouse employed and eligible for other insurance? ☐ No ☐ Yes

TYPE OF COVERAGE
☐ Medical ☐ Family ☐ Single
☐ Dental ☐ Family ☐ Single
☐ Vision ☐ Family ☐ Single
☐ Drug ☐ Family ☐ Single

Name Of Employer (Including address and telephone number)

Name of Other Insurance Company (Including address and telephone number)

Name of policyholder (Usually your spouse) | Policyholder's Identification Number | Account/Group Number | Eff Date

If you are adding an Adult Dependent, is he/she eligible for other coverage either through his/her own employer or that of his/her spouse (if married)? ☐ Yes ☐ No

If Yes, please list dependent name(s) and the name, address, phone number and group/plan number of the other insurance carrier(s):
____
____

Is anyone named on this notice eligible for Medicare coverage? ☐ No ☐ Yes
Name of Person: ___________________________
Reason ☐ Over 65 ☐ Disabled
Part A (Hosp.) Effective Date | Part B (Med.) Effective Date | Medicare Card #

☐ **TERMINATION**
Date Employment Terminated _______________________
Last Day of Coverage ____________________________
☐ Single ☐ Medical ☐ Dental ☐ Vision ☐ All Coverages
☐ Family ☐ Medical ☐ Dental ☐ Vision ☐ All Coverages
VOLUNTARY TERMINATION OF COVERAGE REQUIRES EMPLOYEE'S SIGNATURE BELOW

EMPLOYEE SIGNATURE
Signature is required, except for termination of employment. By signing below you agree to be bound by the terms and conditions for yourself and your dependents. I understand that as an employee, I am required to provide the proper documentation, including birth certificates, marriage certificates, divorce decrees or student records to confirm my dependents proper coverage under these plans, if requested.

X ____ Signature of Insured ________________ Date Signed

EMPLOYER SIGNATURE
____________________ Effective Date of Change ____________________ Signature of Employer ______________ Date Signed

OFFICE USE ONLY
Initial / Date / Comments::