Automated Group Administration, Inc.
7605 Westfield Drive
Fort Wayne, IN 46825
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CHANGE FORM

GROUP NAME: _____ **GROUP#:** _____

EMPLOYEE NAME: _____ **SS #** _____

TERMINATION DATE: _____ **LAYOFF DATE:** _____

CHANGES IN TYPE OF COVERAGE

☐ MEDICAL ☐ DENTAL ☐ VISION ☐ SHORT-TERM DISABILITY ☐ LIFE

PLAN CHANGE(From): _____ **PLAN CHANGE(To):** _____

(EFFECTIVE DATE) _____

REASON FOR CHANGE

☐ DEATH ☐ MARRIAGE ☐ DIVORCE ☐ REDUCTION IN HOURS ☐ BIRTH/ADOPTION ☐ OVER AGE

☐ LOSS OF COVERAGE (INCLUDE DATE COVERAGE TERMINATED)_____ ☐ OTHER _____

DEPENDENT CHANGE

☐ ADD THIS OR THESE DEPENDENTS ☐ DROP THIS OR THESE DEPENDENTS **DATE OF CHANGE:** _____

DEP'S NAME (LAST)	(FIRST, MI)	(SS#)	(DATE OF BIRTH)	(Male/Female)

If dependent child is an Adopted Child or if Employee is the Legal Guardian of child, please attached a copy of the adoption papers or legal guardianship papers.

IS DEPENDENT/SPOUSE COVERED BY OTHER GROUP INSURANCE ? ☐ YES ☐ NO

CHANGE OF ADDRESS

STREET	CITY	STATE	ZIP CODE

CHANGE OF NAME/BENEFICIARY

☐ NAME CHANGE: _____
☐ BENEFICIARY FROM TO

I understand that if a Medical Questionnaire Form is required for any of the changes requested, the change will not become effective until approved by the Underwriting Department. I hereby authorize an increase in my payroll deduction, if any is required, for this change.
THE EMPLOYEE MUST SIGN BELOW FOR ALL OF THE ABOVE CHANGES (except for Employee Termination date and change of address).

SIGNATURE: _____ **DATE:** _____

Revised 202403