MEDICAL & DENTAL GROUP COVERAGE CHANGE FORM

Medical Plan: PKA20386 ______ **0002 RTC** **CL03/CL13/CL07/CL17** ______**0002 Dept of Pub Safety**
Dental Plan: 50825 ______**0002 B School CL01/CL11/CL05/CL15** ______**CL04/CL14/CL08/CL18**

Company Name: **Leech Lake Band of Ojibwe** **Hire Date:**

Enrolled member of Federally recognized Tribe: ☐ **YES** ☐ **NO**

1. **Employee's Name** Last First M.I. 2. **Social Security Number/Subscriber I.D.**

3. **Address**: PO Box/Street City State Zip Code

4. **Change Name To**: Last First M.I>

5. **I wish to change/cancel my coverage.** ☐ **Change** ☐ **Cancel** ***(Waiver needed to cancel)***

From: Medical Coverage: ☐ Single ☐ Family Dental Coverage: ☐ Single ☐ Family

To: Medical Coverage: ☐ Single ☐ Family Dental Coverage: ☐ Single ☐ Family

(List Eligible Dependents for Family Coverage below)

Reason for change (Qualifying Event): ______________________________

Date of Qualifying Event: ______________________________

Complete for all family members applying for coverage. If coverage for dependents is being applied for, **all eligible dependents must be listed.** If a particular line is not applicable, write N/A. **If you are cancelling coverage for a dependent enter the dependent's name and then the date coverage is to be ended under "Effective Date".**
**Include Dependent Status (list all that apply)
A = Adopted, F = Foster Child, C = Step Child, G = Grandchild, N = Natural Child or H = Handicapped

Legal Name (Last, First Middle)		Dep. Status	Social Security #	Gender	Date of Birth	Effective Date	Enrolled member of Federally recognized Tribe
Employee			- -	☐M ☐F	/ /	/ /	☐ YES ☐ NO
Spouse			- -	☐M ☐F	/ /	/ /	☐ YES ☐ NO
			- -	☐M ☐F	/ /	/ /	☐ YES ☐ NO
			- -	☐M ☐F	/ /	/ /	☐ YES ☐ NO
			- -	☐M ☐F	/ /	/ /	☐ YES ☐ NO
			- -	☐M ☐F	/ /	/ /	☐ YES ☐ NO
			- -	☐M ☐F	/ /	/ /	☐ YES ☐ NO
			- -	☐M ☐F	/ /	/ /	☐ YES ☐ NO

- Is any dependent being covered by court order? If yes, who? Name: ____________ (please provide a copy of the court order)

To the best of my knowledge the above information is true and correct and I hereby request the coverage indicated above and authorize my company to deduct the required contributions, if any, from my earnings.

Signature of applicant:______________________________ **Date:**__________