Application for Employee Change

Administered By: Gettysburg Health Administrators, Inc.

404 Baltimore Street, P.O. Box 1060 Gettysburg, PA 17325-1060
Fax: 717-334-5851

Please complete *each* section of this application in ink.

Shaded Area For Office Use Only	Group #:	Eff. Date:	Processed by:	Date:

Applicant Information (Employee)

Name of Employer:	**GettHealth Group ID#**:
Your Name (last, first , initial)	**Social Security Number:** - -

Please make the following changes to my Agreement effective:	**Please make the following changes to the following coverages:**
_____/_____/_____	❑ Health ❑ Dental ❑ Vision ❑ Life/Disability ❑ Long Term Disability

EMPLOYEE SIGNATURE (If employee is not available for signature, the corresponding person needs to write: Not available for signature." The correspondent then signs his/her own signature).

X_____ Date: ____/____/_____

Information Requiring Change/Addition

❑ Name Change: From: _____ To: _____

❑ Change of Address to: Home Address (Street or Route) City, State, Zip Code:

❑ Change of Phone Number to:

❑ Reinstate Date (return from layoff date):

Add Dependent – This form can only be used to add newborn children within 30 days of birth.

	Status	Gender	Date of Birth (mm/dd/yy)	Social Security #	Height (ft – in)	Weight (lbs)	Enroll in Medical	Enroll in Dental	Enroll in Vision
Family Member's Name (last, first , initial)	**CHILD**	❑ M ❑ F	/ /				❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

To Cancel Coverage

❑ Cancel Employee Coverage: (Give reason for cancelling coverage)

❑ Cancel Coverage for the Enrolled Dependents Listed Below (Give reason for cancelling coverage):

	Status	Gender	Date of Birth (mm/dd/yy)	Reason for Cancellation:
Family Member's Name (last, first , initial)	❑ Spouse ❑ Child	❑ M ❑ F	/ /	
Family Member's Name (last, first , initial)	❑ Spouse ❑ Child	❑ M ❑ F	/ /	
Family Member's Name (last, first , initial)	❑ Spouse ❑ Child	❑ M ❑ F	/ /	
Family Member's Name (last, first , initial)	❑ Spouse ❑ Child	❑ M ❑ F	/ /	

Cobra Election (Note: This is to enroll in COBRA only): ❑ Employer over 20 lives ❑ Employer less than 20 lives

❑ Effective Date: ____/____/_____ ❑ Termination Date: ____/____/_____

Please Enroll: ❑ Employee Only ❑ Employee and Dependents ❑ Dependents Only ❑ Core Coverage Only ❑ Core coverage & Non-Core Coverage

Dependent to be enrolled info: _____ _____
Name (last, first , initial) Social Security #

Other Change:

❑ Medicare Supplement Election (only applies to Group under 20 ; send along copy of Medicare card): ❑ Medical Only ❑ Medical with Rx
❑ Please list other change: _____