Northern School District Trust (N.S.D.T.)
c/o CESA #12 618 Beaser Av Ashland, WI 54806
Tel.: (715) 682-2363 Ext 133 Fax: (715) 682-7244
e-mail: jeanw@cesa12.k12.wi.us

Revised 8/19/09 Insurance Change Form

Employer:	Dental Group #	Medical Group #	Plan(s) Affected
Chequamegon	96715	10004965	Dental ☐ Med ☐

Employee's Last Name	First Name	M.I.	Home Phone	Effective Date of Change(s)

S.S.#:	Date of Birth:	Hire Date:

____ Check here if this is a change of name : from: _____ to _____

Street Address/P.O. Box #	City	State	Zip

____ Check here if this is a change of address notice

Coverage Change Request

☐ I request cancellation of ALL coverage under my ___ Family or ___ Single Plan(s).

☐ I request a change from a Single Plan to a Family Plan; An Application form must be sent;

☐ I request a change from a Family Plan to a Single Plan;(All spouse/dependent coverage ceases);

* To remove a spouse and/or a dependent but retain Family coverage please see p.2

Reason For Change

☐ Employee terminated employment Voluntary___ Involuntary__ Retired___

☐ Employee now ineligible because _____

☐ Divorce

☐ Death Circle One: Employee Spouse

☐ Other (please explain) _____

Please See Reverse Side

Spouse/Dependent Coverage Change Request

* Complete only for changes under your Family Plan

(If changing from Single to Family Coverage Check the 2nd box in Coverage Change Request on page 1 and submit with full application;)

Spouse

Full Name	Birthdate	S.S. #
Address (If different than employee's)		

☐ Add Spouse

Reason For Addition

- ☐ Marriage Date of Marriage/Effective Date _____
- ☐ Add Spouse which I previously waived Effective Date _____

☐ Remove Spouse Effective Date _____

Reason For Removal

- ☐ Covered elsewhere
- ☐ Death
- ☐ Divorce
- ☐ Coverage no longer desired

Dependent

Full Name	Birthdate	S.S. #
Address (If different than employee's)		

☐ Add Dependent

Reason For Addition

- ☐ Birth Date of Birth/Effective Date _____
- ☐ Adoption Date of Placement/Effective Date _____
  (Adoption/placement papers must accompany this form)
- ☐ FT Student Status Effective Date _____

☐ Remove Dependent Effective Date _____

Reason For Removal

- ☐ Covered elsewhere ☐ Reached age 19 not a FT Student ☐ Married
- ☐ Other (please explain) _____

Signature of the Employee (Insured)_____ Date _____

Signature of the Employer (Contact)_____ Date _____