



Submit to:

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Legal Name: IGA Group Employee Benefit Trust
Version: IGA / CT / 0409

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EXISTING MEMBER CHANGE/TERMINATION FORM

Please complete this fillable form and click the Submit button. Then save it, print it, sign it and fax it to the number shown above.

SECTION I. GENERAL INFORMATION

Group No. \_\_\_\_\_ Employee Social Security No. \_\_\_\_\_
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_
Employer Name: \_\_\_\_\_ Location: \_\_\_\_\_

SECTION II. CHANGE IN EMPLOYEE INFORMATION

NEW EMPLOYEE INFORMATION

New Name: \_\_\_\_\_ New Phone: \_\_\_\_\_
New Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Required Event Date: (mm/dd/yyyy)

SECTION III. CHANGE IN CURRENT COVERAGE (subject to the plan provisions and plan options selected by your employer)

SELECT HEALTH PLAN CHANGE

CHANGE FROM:

Employee Only EE + Spouse
EE + Child(ren) EE + Family



CHANGE TO:

Employee Only EE + Spouse
EE + Child(ren) EE + Family

Required Event Date: (mm/dd/yyyy)

SECTION IV. CHANGE IN FAMILY INFORMATION (please complete for all persons to be covered)

Table with columns: First Name & M.I., Gender, DOB, F/T Student\*, Height, Weight, Social Security No. Rows include Spouse and multiple Child entries.

Special Enrollment Event (The Plan Administrator may require proof of Special Enrollment Event.)

Marriage Loss of Coverage Newborn / Adoption

Required Event Date: (mm/dd/yyyy)

\* Full time students ages 19 - 24. Student certification required from accredited college. Contact the Plan Administrator for a Student Status form.

SECTION V. TERMINATION OF COVERAGE

Terminate ALL Coverage | Terminate ONLY the following coverage(s): Health Dental Vision STD
Reason for Termination of Coverage: Termination of Employment Reduction in Hrs Death Has other Coverage Divorce/Legal Separation Other

Required Event Date: (mm/dd/yyyy)

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Signature/Verification: \_\_\_\_\_ Date: \_\_\_\_\_