



Health Insurance • Change •

OFFICE USE ONLY

I am: An active employee Retired On the COBRA plan

APPLICANT'S NAME Last First MI		Social Security Number
ACTIVE PAYROLL TYPE	<input type="checkbox"/> Academic <input type="checkbox"/> Monthly <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	Complete home address Plan Name

Check coverage change you wish to make:

- Individual only
 - Individual + spouse*
 - Individual + child*
 - Family*
 - Keep family, add a dependent*
 - Keep family, remove a dependent
 - Remove (name) _____ DOB _____
 - Cancel coverage
 - Other* _____
- CHANGE EFFECTIVE DATE:** _____
- *Below, list all dependents you wish to cover.

PAYROLL DEDUCTION AUTHORIZATION TO MY EMPLOYER (active employees only):

I hereby authorize you to make Elective Employer contributions by reducing my wages and salary by the required contributions for the coverage I have elected under the University System of Georgia/ASU Health Plan and to remit this amount in payment of my contract. This authorization shall continue in effect during my employment or until revoked by me in writing.

I understand that I can change my election only during the annual enrollment period to be effective the following January 1 except for approved changes in my family circumstances. I understand that any change I request because of family circumstances must be consistent with that circumstance.

Signature required

Date signed

Send this completed form to:
Augusta State University
Human Resources
2500 Walton Way
Augusta, GA 30904

Sign here if you are retired or on COBRA

REASON FOR CHANGE IN COVERAGE:

- Change in your employment status
- Change in your spouse's employment status
- Marriage
- Divorce
- Annual open enrollment
- Birth/adoption of dependent
- Death of dependent
- Dependent no longer eligible
- Other:

DATE CHANGE OCCURRED:

• IMPORTANT •
For reimbursement, your healthcare plan may restrict your choice of who may treat you or your family, and, where you or your family may be treated.

Information regarding the University System of Georgia healthcare plan benefits and provider networks are contained within the following:

- Georgia Board of Regents PPO/Indemnity Health Benefits Comparison Chart
- Georgia Board of Regents HMO Health Benefits Comparison Chart

These documents are available at:
<http://www.usg.edu/employment/benefits/>

List all eligible individuals you wish to cover.

2.	Last name	First name	Relationship	SSN	Complete if child is over 19	Gender	Birthdate		
							Month	Day	Year
			<input type="checkbox"/> SPOUSE			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
			Children						
3.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> SSN	<input type="checkbox"/> STEP	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
4.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> SSN	<input type="checkbox"/> STEP	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
5.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> SSN	<input type="checkbox"/> STEP	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
6.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> SSN	<input type="checkbox"/> STEP	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
7.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> SSN	<input type="checkbox"/> STEP	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			

Check here if you are eligible for Medicare:

Part A • Effective date _____

Part B • Effective date _____

Medicare HIC # _____

Check here if other dependents are eligible for Medicare:

Name _____

Part A • Effective date _____

Part B • Effective date _____

*Complete an "Application for Unmarried Dependent Student" form for children over age 19, available at: <http://www.usg.edu/personnel>

HMO ONLY

Information should correspond to the numbers of covered individuals listed above. (#1 is self; #2 is spouse; #3 is a child, etc.)

Primary Care Physician Name	Primary Care Physician ID # (if listed at left)
1	1
2	2
3	3
4	4
5	5
6	6
7	7

Are you or your family currently covered under an ASU or any other group/employer health insurance plan?

Yes No If yes, complete sections A through C below.

A. Name of insurance co. (s) & employer(s)

Self _____

Spouse/dependent _____

B. Effective date(s) of policy & Plan Name & contract number

C. Type of contract Sel Family