KELLY

EXISTING MEMBER TERMINATION / CHANGE FORM

Please print clearly in CAPITAL letters | Please fill in the circles completely

GENERAL INFORMATION

1

Company Name			KELLY Company ID#
Last Name	First Name	MI	Suffix (Jr., III, etc.)
Social Security#	Date of Birth	Employer Phone	

EMPLOYEE TERMINATION OF COVERAGE

2

○ **Terminate ALL Active Lines of Coverage**

Terminate Only: ○ Health ○ Vision ○ Vol. Life ○ Vol. Sp. Life ○ STD ○ LTD ○ Suppl. Life/AD&D ○ Dental ○ Life/AD&D ○ Vol. AD&D ○ Vol. Dep. Life ○ Vol. STD ○ Vol. LTD

Reason for Termination:

○ Death of Employee ○ Loss of Dependent Status ○ Non-Payment of COBRA Premium
○ Employment Status Change ○ Enrollment in Medicare ○ Dropping Coverage Voluntarily ○ Gain of Other Coverage
○ End of Employment ○ Reduction in Hours ○ Court Ordered Cancellation ○ Not Eligible ○ *Other:*

Qualifying Event Date:

Coverage Term Date:

CHANGE IN CURRENT COVERAGE LEVEL

3

MEDICAL ONLY		DENTAL ONLY		VISION ONLY		ALL LINES		OTHER Plan _____	
FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
○ Employee Only	○	○ Employee Only	○	○ Employee Only	○	○ Employee Only	○	○ Employee Only	○
○ Employee & 1 Child	○	○ Employee & 1 Child	○	○ Employee & 1 Child	○	○ Employee & 1 Child	○	○ Employee & 1 Child	○
○ Employee & Spouse	○	○ Employee & Spouse	○	○ Employee & Spouse	○	○ Employee & Spouse	○	○ Employee & Spouse	○
○ Family	○	○ Family	○	○ Family	○	○ Family	○	○ Family	○

Qualifying Event : ○ Marriage ○ Newborn / Adoption ○ Loss of Coverage **Qualifying Event Date:** **Requested Date of Change:**

Last, First, MI	Social Security #	Birth Date	Sex (M/F)	F/T Student (Y/N)*	Disabled (Y/N)	PCP Info (where required)		Existing Patient (Y/N)
						Physician Name	Physician #	
Spouse								
Child								
Child								
Child								

Are you or any of your dependents eligible for Medicare? If Yes: Effective Date (Part A): Effective Date (Part B):

MISCELLANEOUS CHANGES

4

Name Change : From: _____ To: _____

Address Change: From: _____ To: _____

_____ _____

Telephone Number Change: From: ( ) _____ To: ( ) _____

Salary Change: From: $ _____ To: $ _____ Effective Date of Change: ___/___/___

Provider Change: ○ PCP ○ OB/GYN ○ DENTIST Change for all members?: ○ Y ○ N If no, list member name: _____

From: _____ # _____ To: _____ # _____ Existing Patient: ○ Y ○ N

Medicare: ○ Add ○ Drop

Name: _____ Medicare ID #: _____ Part A: ___/___/___ Part B: ___/___/___

Beneficiary Change- Life Insurance: I am changing my group term Life Insurance beneficiary(s) (Please print full name including middle initial)

Primary To: _____ Relationship: _____ Percentage: _____

Secondary To: _____ Relationship: _____ Percentage: _____

5

EMPLOYEE SIGNATURE _____ **DATE** _____

EMPLOYER SIGNATURE / VERIFICATION _____ **DATE** _____

Note: Form invalid without required signatures

Notice of Nondiscrimination and Accessibility:

KELLY complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KELLY does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

KELLY:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact KELLY Corporate Compliance (compliancegroup@kellyway.com).

If you believe that KELLY has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: KELLY Corporate Compliance, 1 Kelly Way, Sparks, MD 21152, compliancegroup@kellyway.com, telephone (443) 589-1980.
You can file a grievance in person or by mail, or email. If you need help filing a grievance, KELLY Corporate Compliance (compliancegroup@kellyway.com) is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.