Revised June 2019

Please complete legibly and in entirety.

Bahama Health
FEEL GOOD ABOUT YOUR HEALTHPLAN

The group division of Family Guardian Insurance Company Ltd.

# GROUP ADVICE OF CHANGE FORM

| | | |
|---|---|---|
| **EMPLOYER'S NAME** | | **Group Number:** |
| **EMPLOYEE'S NAME** | | **I.D. Number:** |
| **1. TERMINATION OF EMPLOYMENT** | **Reason for Termination:** | **Termination Date:** *(mm/dd/yyyy)* _____ |
| **2. SALARY CHANGE** | **New Annual Salary:** | **Effective Date:** *(mm/dd/yyyy)* _____ |
| **3. EMPLOYEE NAME CHANGE** | **From:** **To:** *(Please attach legal documentation. In the event of marriage, please present the marriage certificate.)* | |

**4. ADDITION OF DEPENDENT**

| **Dependent Name** *(first, middle initial, last)* | **Sex** | **Date of Birth** *(mm/dd/yyyy)* | **Relationship** | **NIB #** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**5. TERMINATION OF DEPENDENT**

**Name:** (*First, Middle Initial, Last)* _____

**Birth Date:** *(mm/dd/yyyy)* _____ **Effective Date:** *(mm/dd/yyyy)* _____

**Relationship:**
- ☐ Spouse
- ☐ Daughter
- ☐ Son
- ☐ Other: _____

**6. ADDITION OF BENEFITS**

- ☐ Employee Health
- ☐ Employee Dental
- ☐ Employee Vision
- ☐ Employee Long Term Disability
- ☐ Employee Short Term Disability
- ☐ Dependent Vision
- ☐ Dependent Dental
- ☐ Dependent Life
- ☐ Employee Supplemental Life

**Effective Date:** *(mm/dd/yyyy)* _____

**7. PLAN CHANGE**

| **From:** | **To:** |
|---|---|
| ☐ BahamaHealth Choice Plus _____ | ☐ BahamaHealth Choice Plus _____ |
| ☐ BahamaHealth Select _____ | ☐ BahamaHealth Select _____ |
| ☐ BahamaHealth Value _____ | ☐ BahamaHealth Value _____ |
| ☐ BahamaHealth Hospital Plus _____ | ☐ BahamaHealth Hospital Plus _____ |

**Effective Date:** *(mm/dd/yyyy)* _____

| | | |
|---|---|---|
| **8. ADDRESS OR TELEPHONE CHANGE** | **New Address:** _____ | **New Telephone Number:** _____ **Effective Date:** *(mm/dd/yyyy)* _____ |
| **9. DATE OF BIRTH CHANGE** | **From:** *(mm/dd/yyyy)* _____ | **To:** *(mm/dd/yyyy)* _____ **Effective Date:** *(mm/dd/yyyy)* _____ |
| **10. OTHER** | **Reason:** | **Effective Date:** *(mm/dd/yyyy)* _____ |

_____ Date *(mm/dd/yyyy)*

_____ Telephone Number

_____ Employee Signature

_____ Authorized Signature of Employer