



STATE EMPLOYEE HEALTH PLAN (SEHP) 2013 CHANGE FORM INSTRUCTIONS

Please complete the form in its entirety. Please print clearly and legibly. Make sure the employee and HR Officer both sign and date the form.

1. Effective date of coverage - except for birth of a child, adoption or placement, this will always be the 1st day of the month (required)
2. Employee ID Number (required)
3. Agency **or** Non State Employer Group (NSEGroup) Number (required)
4. Full Name of Employee (required)
5. Employee's new or corrected address (if applicable) including the county. Leave blank if the employee has not moved during the Plan Year. (Please note: the SEHP will not make changes to Active SOK employee addresses.)
6. Valid Employee Contact Email Address (required)
7. Employee's Phone number for telephone contact (required)
8. Employee's Social Security Number or ITIN (required)
9. Employee's Gender (required)
10. Employee's Date of birth (required)
11. Employer adds Coverage Level Codes (found on back of the Change Form) to indicate the Employee's choice(s) (required)
12. If an Employee is electing Direct Bill coverage and wants to choose a different carrier, the Employer indicates the Employee's choice here
13. Employee must indicate their dependent coverage choice(s) (required)
14. Employer must indicate the type of qualifying event that permits changes to be made (required)
15. Employer must indicate any action to be taken with respect to a dependent
16. Enter the Relationship Code (found on the back of the Change Form) of the dependent (required if action affects dependents)
17. Enter the full name of the dependent(s) (required if action affects dependent)
18. Enter the Social Security Number, ITIN or HICN of the dependent(s) (required if action affects dependent)
19. Enter the gender of the dependent(s) (required if action affects dependent)
20. Enter the date of birth of the dependent(s) (required if action affects dependent)
21. Darken the box if the dependent's address is the same as the Member. If not, enter the dependent's address (if the action affects the dependent)
22. Enter the name of the Medicare eligible member (if applicable)
23. Enter the date of eligibility for Medicare Part A (if applicable)
24. Enter the date of eligibility for Medicare Part B (if applicable)
25. Enter the member / dependent's Medicare Claim Number, from the Medicare card (if applicable)
26. Employee's signature and date the form was signed
27. Printed name, signature, signature date, and phone number of the employee's Personnel Officer