INDECS
1099 Wall Street West, Lyndhurst, NJ 07071
1 (888) 4-INDECS (446-3327)
Fax (201) 460-3204

Form #OUSD-4510C-9/17

CHANGE

OU Health

Print Form

For changing existing enrollee/dependent information only. DO NOT use for termination or deletion.

ENROLLEE'S SCHOOL DISTRICT:

TYPE: Last Name | First Name | Initial | SSN

CHECK THE SECTION TO BE CHANGED

ENTER THE CHANGE EFFECTIVE DATE

COMPLETE THE NEW DATA ONLY INSERTING THE "CHANGE TO" INFORMATION

ENROLLEE/MEMBER INFORMATION

CHANGE ☐ PART 1

Last Name | First Name | MI

Address | City | State | Zip Code

SSN | Date Of Birth (M M D D Y Y Y Y) | Sex ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated

Date of Marriage/ Divorce or Legal Separation

COVERAGE

CHANGE ☐ PART 2

TYPE: ☐ Individual (skip to Part 4) ☐ Family (fully complete Parts 3, 4 & 5) Effective Date

STATUS: ☐ Active ☐ Retired ☐ Medicare Effective Date

FAMILY INFORMATION

When applying for other than individual coverage, list all eligible dependents. Indicate relationships by specifying choices. (If other, detail in remarks and submit legal documentation.)

CHANGE ☐
ADD ☐
BOTH ☐
PART 3

		First Name	M	Last Name (If different)	Date Of Birth (M M D D Y Y)	SSN	Effective Date
Spouse	☐ Male ☐ Female					Spouse's SSN is required.	
Dep/Relationship	☐ Male ☐ Female						
Dep/Relationship	☐ Male ☐ Female						

☐ More dependents, complete Change Continuation on next page

Remarks:

OTHER COVERAGE INFORMATION

CHANGE ☐ PART 4

ARE THERE ANY OTHER HOSPITAL, SURGICAL, MEDICAL OR HEALTH BENEFITS OR SERVICES PROVIDED TO YOU, YOUR SPOUSE OR OTHER DEPENDENTS WHICH FURNISH SERVICES OR COVERAGE SIMILAR FOR WHICH YOU ARE ENROLLING? ☐ YES ☐ NO

If yes, complete the following: -- *Other coverage information* --

Person with other coverage	ID or Group #	Single	Family	Plan Name & Address	Effective Date
		☐	☐		

MISCELLANEOUS

☐ PART 5

Detail any changes not covered by this form, or use this area to clarify any of the above changed information.

Effective Date

AUTHORIZATION/CERTIFICATION

I understand that the Plans and coverages listed above shall be in effect until revoked or changed by me in writing. I certify that the information completed above is true and accurate, knowing that falsified or fraudulent disclosures are punishable by law. ***(PRINT, SIGN and DATE ORIGINAL.)***

Print Name | Sign Name | Date

LOCAL ADMINISTRATORS - (MUST BE COMPLETED)

Enrollee's Hire Date | Coverage Effective Date

I certify that I have the original of this document, signed by the Enrollee, which will be maintained by this District.

Print Name | Sign Name | Current Date

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CHANGE Continuation

OU Health

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ENROLLEE'S SCHOOL DISTRICT:

ENROLLEE/MEMBER INFORMATION

Last Name | First Name | Initial | SSN | Date Of Birth (M M D D Y Y) | Sex (M F)

Street Address | City | State | Zip Code | Marital Status: Single Married Divorced Legally Separated

FAMILY INFORMATION

			First Name	M	Last Name (If different)	Date Of Birth (M M D D Y Y)	SSN	Effective Date
CHANGE	Spouse	Male Female					SSN (Spouse's SSN is required.)	
ADD	Dep/Relationship	Male Female					SSN	
BOTH	Dep/Relationship	Male Female					SSN	
	Dep/Relationship	Male Female					SSN	
	Dep/Relationship	Male Female					SSN	
	Dep/Relationship	Male Female					SSN	

Remarks:

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