Change of Health Insurance Status

Your Name:_____

Social Security No.:_____ **Your Birth Date**:_____

Current Address:_____ **Phone:**_____

City:_____ **State:**_____ **Zip Code:**_____

SETS Case No._____

SETS Case No._____

SETS Case No._____

INSURANCE COMPANY:_____

ADDRESS: _____

_____

_____

POLICY #:_____ **GROUP #**_____

BEGIN DATE:_____ **END-DATE:**_____

EMPLOYER NAME AND ADDRESS:_____

_____

CHILDREN COVERED BY INSURANCE:

NAME_____ **NAME**_____

NAME_____ **NAME**_____

_____

Please Sign and Date

Revised on 3/20/2009