MERRILL AREA PUBLIC SCHOOLS
HEALTH PLAN
CHANGE REQUEST FORM

Please return completed form to Merrill Area Public School's Payroll Department.

INSTRUCTIONS: Check and complete the changes that apply and sign where indicated.

Section 1 - Employee Information Changes

Select Plan Type(s) To Update: ☐ Health — Group Number: ASP10053

Employee Last Name	First Name	MI	Aspirus Health Plan ID Number
Spouse Last Name	First Name	MI	

Marital Status: ○ Married ○ Single ○ Widowed ○ Divorced/Separated

☐ **Name Change**	Change From	Change To	Reason For Change
	If Married, Spouse's Name	Date Of Marriage	Date of Divorce, If Applicable

☐ **Phone Number Change**	☐ Home ☐ Work ☐ Cell	Change To
☐ **Email Address Change**	Change To	

☐ **Address Change**	☐ Residence Address ☐ Mailing Address	Street		Apartment Number
		City	State	ZIP Code

☐ **Plan Change**	Change From: ☐ $2,000/$4,000 Signature Network HMO	☐ $2,000/$4,000 Freedom Network Point of Service
	Change To: ☐ $2,000/$4,000 Signature Network HMO	☐ $2,000/$4,000 Freedom Network Point of Service

☐ **Cancel Group Coverage**	Cancellation Date - List First Date Of Ineligibility Requested

Section 2 - Adding or Deleting Coverage for Spouse and Dependents

☐ **Addition Of Spouse Or Dependents**

Last Name	First Name	MI	Gender	Date Of Birth	Relationship To Member	Social Security #
Last Name	First Name	MI	Gender ○ M ○ F	Date Of Birth	Relationship To Member	Social Security #
Last Name	First Name	MI	Gender ○ M ○ F	Date Of Birth	Relationship To Member	Social Security #
Last Name	First Name	MI	Gender ○ M ○ F	Date Of Birth	Relationship To Member	Social Security #

☐ **Deletion Of Spouse or Dependents**

Last Name	First Name	MI	Date Of Birth	Termination Date
Last Name	First Name	MI	Date Of Birth	Termination Date
Last Name	First Name	MI	Date Of Birth	Termination Date

Employee Signature_____ Date_____