

## PARTICIPANT ENROLLMENT

### Change Form

**COMPANY NAME** \_\_\_\_\_

(PLEASE PRINT)

#### EMPLOYEE INFORMATION

SSN		
Last Name	First Name	MI
Type of Change: <input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change      Effective Date of Change:		

#### ADDING DEPENDENTS INFORMATION

Last Name	First Name	MI	SSN
Address (If different from participant)			DOB
City	State	Zip Code	<input type="checkbox"/> Male <input type="checkbox"/> Female
Daytime Phone #	Evening Phone #		<input type="checkbox"/> Single <input type="checkbox"/> Married
Email Address	Occupation		
Relationship to Participant: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			Qualifying Event Date
Qualifying Event: <input type="checkbox"/> Marital Status <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Other (Specify)			

#### TERMINATING COVERAGE

TERMINATE: <input type="checkbox"/> Entire Family <input type="checkbox"/> Selected Individual(s)		Date of Termination
Last Name	First Name/MI	SSN
Last Name	First Name/MI	SSN
Last Name	First Name/MI	SSN
Last Name	First Name/MI	SSN
Reason for Termination: <input type="checkbox"/> No Longer Employed <input type="checkbox"/> Decreased Hours <input type="checkbox"/> Change in Location/Benefits <input type="checkbox"/> Other (Specify)		

***I agree to allow the release of any information, including medical information, necessary for AXIS and/or agents to fulfill their obligations under the terms of the Plan. I attest that the information provided here is true and accurate to the best of my knowledge. I understand any intentionally false statement may invalidate coverage.***

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Participant Signature

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Date

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Employer Representative Signature

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Date