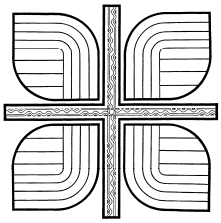

# SERVICE / CHANGE FORM

This form is used to report changes in coverage and cancellation of coverage. Please complete and fax to AssuredPartners at 237-0190.

The following event(s) have occurred which may affect my benefits. Please send the necessary forms to my attention for completion.

DATE OF EVENT

- ☐ MARRIAGE _____
- ☐ BIRTH OR ADOPTION OF CHILD _____
- ☐ DIVORCE _____
- ☐ BENEFICIARY CHANGE _____
- ☐ TERMINATION OF EMPLOYMENT _____
- ☐ DEATH _____
- ☐ DEPENDENT NO LONGER ELIGIBLE _____
- ☐ MEDICAL OR DENTAL CLAIM INQUIRY. Attach copies of bills, Explanation of Benefits, or provide details below. Include date(s) of service, patient's name, etc.
- ☐ OTHER. Please provide details:

_____

_____ _____

Employee Name Social Security Number

_____ _____

Person Completing Form, If Different Date

_____ _____

Name of School / Parish Phone Number