CHANGE ACTION FORM

INSTRUCTIONS TO EMPLOYER Have employee type or print clearly. After completing, send form to NBI.

TO: NATIONAL BENEFITS INC.
P.O. BOX 263
PARSIPPANY, NJ 07054

Name of Company (as shown on your billing):

Name of Employee: ID#

Group Number:

CHECK ALL NEEDED

A ☐ Change Name
B ☐ Change Beneficiary
C ☐ Change Employee Coverage
D ☐ Change Classification
E ☐ Benefit Termination
F ☐ Other (Mandatory Signatures)

Effective Date of Change

A NAME CHANGE MY NAME From: ______________ To: ______________
REASON FOR CHANGE ______________ Date: ______________

B BENEFICIARY Change My Beneficiary From ______________ To:

(Name) (Relationship) (Date of Birth)

C CHANGE EMPLOYEE COVERAGE TO:

☐ Life Only
☐ Single (employee only)
☐ Employee & 1 dependent child
☐ Employee & Spouse
☐ Employee & Children
☐ Employee, Spouse & Children

SHOW REASON AND DATE OF EVENT WHICH CAUSED THE CHANGE

☐ Marriage
☐ Birth
☐ Death
☐ Separation
☐ Divorce
☐ Age Limit
☐ Other — please explain ______________

Date of Event ______________

Name of spouse to be excluded ______________

IF YOU ARE ADDING A DEPENDENT NOT PREVIOUSLY COVERED, YOU MUST FULLY COMPLETE REVERSE SIDE OF THIS FORM.

D CLASSIFICATION CHANGE

UNDER THE TERMS OF THE PLAN DOCUMENT, I HEREBY DECLARE THAT THE ABOVE EMPLOYEE WILL BECOME (BECAME) ELIGIBLE FOR BENEFITS PROVIDED FOR CLASS ______ (Number) EMPLOYEES AS SET FORTH IN THE PLAN DOCUMENT.

EFFECTIVE ______________ (Date) BECAUSE ______________ (Reason)

(Signature of Employer or Officer of Employer)

E BENEFIT TERMINATION

☐ LIFE
☐ HEALTH
☐ OTHER

DATE ______________

REASON ______________

I decare statements and answers herein are complete and true and understand they are the basis for providing coverage under a Plan Document issued by my employer.
I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, Insurance Company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health, or records or knowledge of my spouse or any of my sons or daughters or records or knowledge of their health to give to NBI any such information. A photographic copy of this authorization shall be valid as the original, and shall remain valid for a period of thirty (30) months.
I Understand; (a) that a copy of this authorization is available to me upon written request to NBI and (b) that no coverage shall become effective unless and until evidence of insurability is approved by the Plan Administrator.

F

WITNESS DATE SIGNATURE OF INSURED

PLEASE COMPLETE ENTIRE FORM AND ALL HEALTH QUESTIONS

Company Name : ______________________ Group No: ______________

Employer's Address : ______________________

Name of Employee: ______________________ Date of Employment ______________

Date of Birth: _______ Height: __________ Weight: __________ Occupation: __________

Name of Dependent (s)	Relationship	Date of Birth	Height	Weight

THE FOLLOWING QUESTIONS MUST BE ANSWERED —

HEALTH HISTORY FOR ALL PERSONS TO BE INSURED

Have you or any of your dependents

1 YES NO ever suffered from or been suspected of having any ailment or disease of
- A The Brain or Nervous System?
- B The Heart, Lungs, Pleurae or Chest?
- C The Stomach or Intestines, Liver, Kidneys, Bladder, Rectum or Gall Bladder?
- D The Skin, Middle Ear, Eyes, Nose or Throat?

2 ever had, been told that you had or been treated for
- A High or low blood presure?
- B Rheumatism, Gout, Syphilis, Cancer Tumor or Growth?
- C Blood spitting or pain in chest?
- D Diabetes or Tuberculosis?
- E Anemia, hemophilia, goiter or other disease or disorder of the blood or glands or immune system?
- F Alcoholism or drug addiction?

3 ever had or been treated for an accident or injury?

4 ever been a patient in a hospital, sanitarium or institution?

5 ever had any disability or deformity, lameness, rupture, or any impairment of sight or hearing?

YES NO

6 ever had any abnormalities, disease or disorder of the reproductive organs or breasts, menstruation or pregnancy whether male or female, or are you or any of your dependents now pregnant?

7 any physical defect or complaint not mentioned above?

8 been absent from work due to illness or injury during the past six months?

9 Are you or any dependent to be insured taking prescribed medication of any kind?

10 had a surgical operation?

11 consulted a doctor during the past five years for any cause not included in the above answers? (If routine check-up, give details of symptoms and treatment or specify "none," if there were none.)

12 If the answer to any of the above questions is 'yes' give details below.

NAME OF PERSON	SYMPTOMS OR AILMENT AND TREATMENT RECEIVED	ONSET DATE	RECOVERY DATE	ADDITIONAL TREATMENT NEEDED OR RECOMMENDED

13 **Have you or any of your dependents ever had an application for life, or health insurance declined, postponed, cancelled or refused renewal?**
_____ Yes _____ No If yes, state names of companies, dates and reasons.

Answer all parts of the following question if benefits include Dental Coverage

14 Have or are you or any of your eligible dependents to be included:

	YES	NO
A. Now in need of dental treatment of any kind?	☐	☐
B. Consulted a dentist during the last 12 months?	☐	☐
C. Been advised that dental work was necessary or desirable, or is such dental work contemplated?	☐	☐
D. If the answer to C is 'yes,' has all this work been completed?	☐	☐

I declare statements and answers herein are complete and true and understand they are the basis for providing coverage under a Plan Document, issued by My Employer.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, Insurance Company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health, or records or knowledge of my spouse or any of my sons or daughters or records or knowledge of their health to give NBI, Inc. any such information. A photographic copy of this authorization shall be valid as the original, and shall remain valid for a period of 3 months.

I Understand: (a) that a copy of this authorization is available to me upon written request to NBI, Inc. and (b) that no coverage shall become effective unless and until evidence of insurability is approved by the Plan Administrator.

15 Signature of employer's authorized representative

16 **Signature of applicant - (If health coverage is for adult dependent, that adult dependent must sign this form)**

17 Date