

Subscriber Service Form – Plan Year 2010

Group Name: State of Kentucky Agency Name : _____

Subscriber Name: _____ SS# _____ - _____ - _____

OR Payroll ID _____

A. CHANGES:

Name: From: _____

To: _____

Address To: _____

City _____ State _____ Zip _____

Telephone To: () _____

Add Dependent:

Name _____ Birth Date ___/___/___ Male ___ Female ___

Name _____ Birth Date ___/___/___ Male ___ Female ___

Name _____ Birth Date ___/___/___ Male ___ Female ___

Delete Dependent:

Name _____ Effective Date ___ / 1 / ___ Male ___ Female ___

Name _____ Effective Date ___ / 1 / ___ Male ___ Female ___

Name _____ Effective Date ___ / 1 / ___ Male ___ Female ___

Effective Date of Change: ___ / 1 / ___ (DATE MUST BE THE 1ST OF THE TERMINATION MONTH)

B. Terminate Policy (Reason) _____

Date of Termination ___ / 1 / ___

C. Reinstate Policy (Reason) _____

Effective Date of Reinstatement

___ / 1 / ___

D. Plan Change:

C250Z

From: AVK3

To: AVK3

PPO 510

PPO 510

**New Premium
Deduction:**

\$ _____

E. Other(Explain) _____

Signature _____

Person initiating request (subscriber, administrator, etc.)

Fax Changes to: 502-875-3615
*****Please be sure your Group # are on all forms before faxing!*****