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**	☐ **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!********