Please send to : NovaSys Health
Attn: Enrollment Department
P.O. Box 25230
Little Rock, AR 72221
Fax: 501-975-4811

CHANGE FORM

EMPLOYEE INFORMATION

EMPLOYEE NAME: (FIRST, M.I., LAST)		EMPLOYER NAME:
EMPLOYEE ADDRESS: STREET	CITY	STATE ZIP
PHONE #:	SOCIAL SECURITY #:	GROUP #:

TYPE OF CHANGE

☐ Change to Family Plan	☐ Add Spouse / Dependents	☐ Cobra Coverage	☐ Name Change
☐ Change to Individual Plan	☐ Delete Spouse / Dependents	☐ Address Change	☐ Termination

COMPLETE APPLICABLE SECTION(S)

* Requires copy of legal document of qualifying event

ADD SPOUSE / DEPENDENTS

FIRST NAME	M.I.	LAST NAME	SOCIAL SECURITY #	DOB MO / DAY / YR	SEX M / F	RELATIONSHIP TO INSURED
REASON FOR CHANGE:						
EFFECTIVE DATE:						

DELETE SPOUSE / DEPENDENTS

FIRST NAME	M.I.	LAST NAME	SOCIAL SECURITY #	RELATIONSHIP TO INSURED
REASON FOR CHANGE:				
EFFECTIVE DATE:				

OTHER INSURANCE

ARE YOU OR YOUR DEPENDENTS COVERED BY ANY OTHER GROUP HEALTH INSURANCE PLAN? (CIRCLE ONE)	EMPLOYEE YES NO	SPOUSE YES NO	DEPENDENT CHILDREN YES NO

REMARKS: IF YOU INDICATED "YES" TO THE ABOVE, PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING THE OTHER GROUP HEALTH INSURANCE COVERAGE.

EMPLOYER OR GROUP NAME		GROUP #	EFFECTIVE DATE
ID # POLICYHOLDER	POLICYHOLDER DOB	RELATIONSHIP TO APPLICANT	
NAME & ADDRESS OF INSURANCE COMPANY			TELEPHONE #

STUDENT COVERAGE

IF CHILD IS OVER 18, HE/SHE IS A FULL TIME STUDENT AT:
NAME OF COLLEGE

ADDRESS OF COLLEGE	TELEPHONE # OF COLLEGE

DO ALL COVERED DEPENDENTS LIVE WITH EMPLOYEE? ☐ YES ☐ NO IF "NO", LIST DEPENDENTS, RESIDING CITY, RESIDING STATE AND EXPLAIN:

ADDRESS CHANGE

NEW ADDRESS: STREET CITY STATE ZIP NEW PHONE #:

NAME CHANGE *

CHANGE FROM: (FIRST, M.I., LAST)	EFFECTIVE DATE OF CHANGE:
CHANGE TO: (FIRST, M.I., LAST)	
REASON FOR CHANGE:	

TERMINATION

LAST DAY WORKED:	TERMINATION DATE OF BENEFITS

EMPLOYEE SIGNATURE:________________________________ DATE: ________________________

If you have any questions, please call 501-219-4444 or 877-362-9003

Please make a copy for your records if needed.