SECURIAN™

Membership Maintenance Form

PART A – EMPLOYEE INFORMATION

Employee's Name:	Last	First	Middle Initial				Social Security Number / /	
Gender:	Male ☐	Female ☐	Marital Status:	Single ☐	Married ☐	Widowed ☐	Divorced ☐	Legally Separated ☐	Date of Birth (Month-Day-Year) / /
Employee's Address: ☐ Check If New Address	Address					Home Phone Number		Work Phone Number
	City		State		Zip Code			

PART B – CHANGE REQUEST - Check All Categories That Apply – Provide Information Requested By Category

☐ **Name Change**
Former Name: _____
New Name: _____

☐ **Terminate Employee and All Dependent Coverage**
Date of Termination: ___/___/___
Date Coverage Ends: ___/___/___

☐ **Change Employee Group/Subgroup** (Move individual to different group/subgroup number, including COBRA subgroup)
From: _____ To: _____
Effective Date of Change: ___/___/___

☐ **Change Plan Option at Open Enrollment** (Applies only if Group offers multiple Plan Options)
I elect to participate in the following Plan:
☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D

☒ **Change Coverage Type Due to Qualifying Event** – List Qualifying Event Code next to correct Coverage Type and complete Part C if Adding or Dropping Dependents **Qualifying Event Code:** A – Adoption B – Birth D – Divorce/Legal Separation E – Death L – Loss of Coverage M – Marriage O – Group Open Enrollment S – Dependent No Longer Eligible

Qualifying Event Code	Coverage Type Change Request Category	Date of Qualifying Event	Effective Date of Change
	Employee Only	/ /	/ /
	Employee & Spouse	/ /	/ /
	Employee & Dependent Child(ren)	/ /	/ /
	Family	/ /	/ /

PART C – DEPENDENT INFORMATION – Adding or Dropping Dependents May Require a Coverage Type Change in Part B

Add	Drop	Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only If Different From Employee's)	Gender		Date of Birth Month/Day/Year	Full Time Student?		Unmarried?	
		Spouse		M	F	/ /				
		Dependent Child		M	F	/ /	Y	N	Y	N
		Dependent Child		M	F	/ /	Y	N	Y	N

PART D - EMPLOYEE SIGNATURE – See Instructions for additional information.

I choose to make changes as indicated on this form and authorize payroll deduction, if applicable. If Part E is completed, I have elected to continue coverage under this plan due to the qualifying event indicated above and I understand that in order to retain my coverage continuation, I must meet the required payment obligations and/or other conditions as may be required.

Employee Signature: **Date:**

PART E – COBRA – Employee Note: Complete Only if enrolling for COBRA benefits Employer Note – May require subgroup change

Select One: ☐ Group Billed ☐ Direct Billed

Select Qualifying Event Number:
1 Employee Termination or Reduction of Work Hours
2 Employee Death
3 Employee Total Disability
4 Divorce or Legal Separation
5 Employee Eligible For Medicare
6 Dependent No Longer Eligible

Coverage Continuation Applies To:	Event Number	Date of Qualifying Event	Social Security Number
☐ Employee & All Dependents Currently Enrolled		/ /	
☐ Employee Only		/ /	
☐ Spouse Only		/ /	- -
☐ Dependent(s) Only – List Names in Part C		/ /	- -
☐ Employee & Spouse		/ /	
☐ Employee & Dependent Child(ren)–List Names in Part C		/ /	

PART F – GROUP INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

Group Name: Brunswick School Dept **Group & Subgroup Numbers:** 8093 - 0103

Group Representative's Signature: **Date:** **Phone Number:** (207) 3191900