



**Beneficial Employees Security Trusts
REQUEST FOR CHANGE OF STATUS**

Employee Name - Last	First	Middle	ADD . Dep Cov	Employer Number	Eff. Date of Change
Name of Company Where Employed			Incr/Decr	EE #	Coverage
EMPLOYEE CHANGE OF NAME					
New Name - Last	First	Middle	Term Dep. Cov.	Adjustment	App=A Decl=D

THE FOLLOWING MUST BE ANSWERED BY ALL EMPLOYEES, REGARDLESS OF CASE SIZE:

- 1) Have any of your dependents applying for coverage received \$10,000 in benefits during the last 12 months? Yes NO
- 2) Have any of your dependents applying for coverage been hospitalized in the last 12 months? YES NO

If any questions are answered "Yes," please complete the "Statement of Health" on the reverse side.

ADDITION OF DEPENDENT(S)							TERMINATION OF DEPENDENT(S)	
If Adding a spouse, enter date of marriage: Mo _____ Day _____ Year _____							Requested Date of Termination: Mo _____ Day _____ Year _____	
Dependent Name	Full-Time Student	Relationship	Sex	Height	Weight	Date of Birth	<input type="checkbox"/> Terminate all dependents <input type="checkbox"/> Terminate Spouse <input type="checkbox"/> Terminate Child Name of Dependent _____	REASON <input type="checkbox"/> Death <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Over Ins. Age <input type="checkbox"/> Age 65 <input type="checkbox"/> Other _____
<input type="checkbox"/> Check here if dependent applying for coverage was previously insured as an employee with the employer.							<input type="checkbox"/> Check here if dependent terminated will be enrolling with this employer	

PLEASE SEE THE REVERSE SIDE

Your Signature in Ink	Date Signed
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Health Plans

STATEMENT OF HEALTH

The following must be answered by all employees of firms with less than 15 covered employees.

The following information is submitted as evidence of my dependents insurability, if required. Have any dependents applying

- In the past two years (other than for routine examination, check-ups, immunizations) consulted or been treated by a physician/practitioner, or been confined or treated in a hospital or similar institution, or been advised to have an operation which has not been performed, or been advised to enter a treatment program that they have not yet entered? Yes No
- In the past five years had or been told of, or consulted with a physician/practitioner for, or been treated for:

	Yes	No		Yes	No		Yes	No
Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>	Brain Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Nervous/Mental/ Psychological Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Sugar/Albumin in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Birth Defect or Deformity					
Disease/Disorder of Back or Spine	<input type="checkbox"/>	<input type="checkbox"/>	of bones of Head or Face	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Been declined on a previous health insurance application				<input type="checkbox"/>	<input type="checkbox"/>

Please fully explain all "Yes" answers to questions 1 and 2. Include date of onset, diagnosis, all details of condition, and details of routine exams, names and addresses of Practitioners and Hospitals.

First Name of Dependent	Nature of illness or injury and Date and Duration of Medical Attention	Complete Recovery	Names and Addresses Practitioners/Hospitals
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Yes <input type="checkbox"/> No <input type="checkbox"/>	

I declare that all of the statements contained in this application are, to the best of my belief and knowledge, true and correct and that no material information has been withheld or omitted concerning the past or present state of health of my dependents, and that any misstatements or omissions shall make any insurance based on this application void at the option of the insurer.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company or other organization, institution or person that have any records or knowledge of my dependents or their health, to give to the Beneficial Employees Security Trust any such information. I know that I may request to receive a copy of this Authorization. I agree that a photographic copy of this Authorization shall be valid as the original and that this Authorization shall be valid for two years from the date I sign this application.

Signature of Employee in Ink	Date
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