

Group Benefits Change Form

➔ Email to insurance@agentbenefits.net or Fax completed form to **(856) 396-3193** ➔

INSTRUCTIONS:

- 1) This form is for Dergalis Associates use only. **DO NOT send to the Insurance Carrier.**
- 2) Form must be received in our office no later than 2 weeks prior to the change date.
- 3) Please fill out form using **BLACK INK only.**
- 4) Need help? Call the group insurance department at (888) 564-0300


YOUR INFORMATION	
REALTOR NAME	_____
REALTY COMPANY	_____ CELL PHONE _____
SOCIAL SECURITY #	EMAIL <small>REQUIRED FOR CONFIRMATION PURPOSES</small>

CHANGE OF ADDRESS OR NAME CHANGE	
EFFECTIVE DATE:	OLD ADDRESS/NAME: _____
_____	NEW ADDRESS/NAME: _____

DELETE A DEPENDENT <small>To add a dependent, you must obtain an enrollment application</small>	
EFFECTIVE DATE: <small>(Must be 1st day of next month)</small>	<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <u>NAME OF DEPENDENT</u> _____
_____	RELATIONSHIP _____ SOCIAL SECURITY # _____
	Reason for change: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Child reached age 26 <input type="checkbox"/> Got married

CANCEL COVERAGE / REPORT SEPARATION OR TERMINATION <small>Please call for information about a reduction of your monthly cost by lowering your benefit amounts</small>	
EFFECTIVE DATE: <small>(Must be 1st day of next month)</small>	<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> Short-Term Disability <input type="checkbox"/> Long-Term Disability
_____	Reason for change: <input type="checkbox"/> Obtained private coverage <input type="checkbox"/> Enrolled with spouse's employer
	<input type="checkbox"/> Separation from Real Estate Company (if yes, last day of work _____)
	<input type="checkbox"/> Other _____

DON'T FORGET!

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- To compare any new coverage against what you have now
 - To make sure you are eligible on a spouse's policy before you cancel
 - To confirm the effective date of new coverage so it coincides with your cancellation date
 - That dependent coverage terminates when you cancel any group policy
 - That if you cancel a Life or Disability policy and choose to participate again at a later date, medical underwriting will be required

My signature below authorizes Dergalis Associates and USI Affinity to make the changes I have indicated above.

SIGNATURE
of realtor _____

DATE _____

PLEASE NOTE: THIS FORM **DOES NOT CANCEL** ANY TAX ACCOUNT OR RETIREMENT ACCOUNT