



**BenefitMall.com**™ 10540 York Road  
P.O. Box 8039  
Cockeysville, MD 21030

Employer \_\_\_\_\_  
BMLL Group # \_\_\_\_\_  
BMLL Team # \_\_\_\_\_  
Carrier Group # (See Coverage Boxes)  
(Special instructions on reverse)

## CHANGE REQUEST

Employee First Name \_\_\_\_\_ Employee Last Name \_\_\_\_\_ Social Security No. \_\_\_\_\_ Effective Date of Change \_\_\_\_\_

<input type="checkbox"/> <b>Name Change (Last, First, M.I.)</b> Old Name _____ New Name _____	<input type="checkbox"/> <b>Address Change: Enter new address</b> _____ _____
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**Beneficiary Change**  
 I hereby revoke any current designation and change beneficiary to:  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ % of Benefit \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ % of Benefit \_\_\_\_\_

**Add Coverage: Check benefits being added. If adding dependents enter information below.\***

<b>MEDICAL PLAN</b> <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Indemnity <input type="checkbox"/> HMO <input type="checkbox"/> HMO Opt Out Carrier _____ Carrier Group # _____ <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & One Child <input type="checkbox"/> Family <input type="checkbox"/> Over 65 & Retired <input type="checkbox"/> Over 65 & Working <input type="checkbox"/> None	<b>DENTAL PLAN</b> <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Indemnity <input type="checkbox"/> HMO <input type="checkbox"/> HMO Opt Out Carrier _____ Carrier Group # _____ <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & One Child <input type="checkbox"/> Family <input type="checkbox"/> None <input type="checkbox"/> <b>OTHER</b>	<b>VISION PLAN</b> <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Indemnity <input type="checkbox"/> HMO Carrier _____ Carrier Group # _____ <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & One Child <input type="checkbox"/> Family <input type="checkbox"/> None	<input type="checkbox"/> <b>LIFE AND AD&amp;D</b> <input type="checkbox"/> None <input type="checkbox"/> <b>SUPP. LIFE \$</b> _____ <input type="checkbox"/> <b>DEP. LIFE</b> Carrier _____ <input type="checkbox"/> <b>STD</b> <input type="checkbox"/> None <input type="checkbox"/> <b>VOL. STD</b> PLAN # _____ BENEFIT \$ _____ / WK Carrier _____ <input type="checkbox"/> <b>LTD</b> <input type="checkbox"/> None <input type="checkbox"/> <b>VOL. LTD</b> Carrier _____
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**Cancel Coverage: Check coverage being deleted.**  
 Medical  Dental  Vision  Life  Short Term Disability  Long Term Disability  Other \_\_\_\_\_  
 Reason:  No longer employed  Death  Other \_\_\_\_\_  
 If cancellation is due to termination of employment, indicate last date worked \_\_\_\_\_

**Change Coverage: If adding dependents, enter information below.\* (i.e. from Medical/Employee Only to Medical/ Family)**  
 From: \_\_\_\_\_ To: \_\_\_\_\_  
 If change is due to marriage, please complete: Date of Marriage \_\_\_\_\_

**Complete if Dependent Coverage Requested and for Managed Care Information\***

Last,	Full First,	M.I.	Social Security Number	Birth Date	Sex	Dis-abled (Y/N)	Medi-care (Y/N)	Stu-ent (Y/N)	If POS or HMO, Name of Primary Physician & Medical Center #	Existing Patient (Y/N)
Emp										
Sp										
Chd										
Chd										
Chd										

**PARTICIPATING DENTIST:** \_\_\_\_\_ **DENTAL OFFICE #:** \_\_\_\_\_

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

EMPLOYER SIGNATURE/VERIFICATION \_\_\_\_\_ DATE \_\_\_\_\_

## SPECIAL INSTRUCTIONS (Please Print)

- Name Change: Enter complete old and new names. Last name, first name, middle initial.
- Address Change: Enter new address only.
- Beneficiary Change: Enter new beneficiary name, relationship (e.g., spouse, mother, son, etc.). Percentage of benefit should be 100 if one beneficiary chosen. If more than one beneficiary, enter multiple names and indicate percentage breakdown.

### COVERAGE CHANGES\*

- Add Coverage(s): To add a coverage, mark box titled "Add Coverage" and check appropriate box(es). If adding a coverage which includes dependents, enter dependent information in the bottom box on the form. For medical coverage, the social security numbers must be included.
- Cancel Coverage(s): To cancel coverage, mark box titled "Cancel Coverage" and check appropriate box. Checking one of these boxes will also delete any dependents being covered for that coverage.

Maryland State law requires that cancellation notice of group health (medical, dental and CareFirst BCBS vision) must be received by the last day of the month prior to the requested termination date of that coverage. For example, a request to terminate coverage effective 8/1 must be received by BenefitMall.com no later than 7/31. If notification is received after the requested date of change, a daily charge for the coverage being canceled will be applied up to and including the date the late notice is received. This rule also applies when removing a dependent from an active membership (i.e., spouse, over age dependent child). Please note: fax transmissions received after 3:00 p.m. are counted as arriving on the next business day.

- Change Coverage: To change coverage, mark box titled "Change Coverage." Write in the spaces provided the old coverage and the new coverage. If changing to a coverage which includes dependents, enter dependent information in the bottom box on the form. For medical coverage, the social security numbers must be included.

Example: From: Medical/Employee Only To: Medical/Family  
From: Dental Employee & Spouse To: Dental/Family

- Dependent and Managed Care Information: If adding dependents, make sure you complete all the information in this section including selection of the primary care physician and/or dentist.

- Signature: Employee and Employer must sign and date the form.

\* Coverage changes may require completion of a health questionnaire or other pertinent information.