

<b>SECTION A – GENERAL INFORMATION</b> (Please print in blue or black ink)	
Employee's last name, first name, middle initial	Social Security Number
Group Name	Group #

<b>SECTION B – SUBSCRIBER/DEPENDENT TERMINATION</b>				
Last name, first name	Social Security Number	Effective Date	Termination Date	Reason Code *

\*Please choose a reason from the list and enter it above in the Reason Code column.  
**R**- resignation   **T**-death   **E**-eligible for other coverage   **D**-divorce   **N**-no longer meets eligibility requirements   **M**-Medicare eligible  
 Note: As a result of Subscriber termination, Destiny Health may be due a refund for overpayment of funds from the personal Medical Fund (PMF).

<b>SECTION C – ADDING A DEPENDENT</b>						
Last name, first name	Social Security Number	Effective Date	Date of Birth	Sex	Reason Code *	Other Coverage (Y or N)

\*Please choose a reason from the list below and enter it in the above reason code column  
**N**-newborn   **F**-foster child   **A**-adopted child   **G**-legal guardian   **M**-marriage   **L**-loss of previous coverage   **S**-stepchild

<b>SECTION D – COORDINATION OF BENEFITS (If applicable)</b>			
Policyholder's Name	ID Number	Plan Number	Effective Date
Insurance Carrier's Name	Address		Phone Number
Employer's Name	Employer's Address		Employer's Phone Number
Please list who is covered:			

<b>SECTION E – PMF CHANGE</b>
Due to the qualifying event, please indicate your PMF election amount. Note: This amount will be effective as of the effective date stated in Section B or C. <b>Requested yearly PMF election:</b> _____

<b>SECTION F - SIGNATURE</b>
Employee Signature: _____ Date: _____ Submit the completed form to: Destiny Health Attn: Employer Services, 1211 W. 22 <sup>nd</sup> St., Suite 305, Oak Brook, IL 60523 or fax (630) 928-0751.

PLEASE RETURN THIS FORM TO YOUR EMPLOYER