GUARDIAN® — In alliance with — Destiny Health™

The Destiny Health Plan
Change of Status

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

SECTION B – SUBSCRIBER/DEPENDENT TERMINATION				
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: Upon termination of the Subscriber, you will be responsible to refund any overpayment of funds from your Personal Medical Fund (PMF).

SECTION C – ADDING A DEPENDENT						
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

SECTION D – COORDINATION OF BENEFITS (If applicable)			
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:			

SECTION E – PMF CHANGE
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. **Requested yearly PMF election:**_____

SECTION F – SIGNATURE
Employee Signature:_____ Date:_____ Submit the completed form to: Destiny Health Attn: Employer Services, 1211 W. 22nd St., Suite 221, Oak Brook, IL 60523 or fax (630) 928-0751.

PLEASE RETURN THIS FORM TO YOUR EMPLOYER