



Subscriber Change Request Form

(For Existing Employees Only)

Effective Date of Change

____ / ____ / ____

Firm Name: _____

Client Code: _____

Subscriber Information:

Current Last Name	First Name	MI	Employee SSN	Date of Birth
Street Address (No P.O. Boxes)			Home Phone/Cell Phone	Business Phone
City	State	Zip	Email	Gender

This Change Applies to:

<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
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Please Change My Plan As Indicated:

Add dependent(s) (Eligible dependents are your spouse/domestic partner and children within the agreement in your contract. Coverage granted to individuals listed here shall be subject to all provisions and limitations of the agreement.)

If adding spouse/domestic partner, provide effective date of marriage/domestic partnership: _____

Add Overage Dependent at Single Employee Rate

Delete dependent(s)

Address Change

Change my name as shown. My former name was: _____

Other:

Required- Indicate the reason for this change:	_____
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Member Information: Please note: Under the Medicare, Medicaid and State Children's Health Insurance Plan Extension Act of 2007 Social Security numbers for ALL family members are required. For additional info please refer to www.cms.hhs.gov/MandatoryInsRep.

Add or Delete		Last Name	First Name	MI	Gender	SSN	Date of Birth	Full-Time Student	Disabled
<input type="checkbox"/> Add <input type="checkbox"/> Del	You								
<input type="checkbox"/> Add <input type="checkbox"/> Del	Spouse/ Domestic Partner				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Del	Child				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Del	Child				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Del	Child				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Del	Child				<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Subscriber Signature _____ Date: _____

Firm Administrator _____ Date: _____

Please return the completed form via:

Mail:

Fax: 877-237-4519

Email: cpaprotectplus@banyan-llc.com

For assistance in completing this form call 877-480-7923

Banyan Administrators, LLC

1215 Manor Drive, Suite 200. Mechanicsburg, PA 17055

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