CHANGE FORM

PLEASE PRINY OR TYPE

This form must be completed if there is (are) any change(s) in any item affecting your status. Failure to notify of any change(s) may affect your benefits. Send this form to: SBOANJ, 64 Business Route 33, Manalapan, NJ 07726

Last Name First M.I.	Change Name to:

Social Security #	Sex ☐ M ☐ F	Date of Birth

Change Address to:	City, State, Zip	Phone #

Add or Remove Dependent(s)

Check Reason

☐ Marriage ☐ Birth of Child ☐ Divorce ☐ Death Other: _____

Add or Remove	Last Name First	DOB	Sex ☐ M ☐ F	Relation to Member	Social Security #
Add or Remove	Last Name First	DOB	Sex ☐ M ☐ F	Relation to Member	Social Security #

Update Coverage

Requesting Termination	Requesting Change in Coverage (selection below)

Group I: Groom

	Single	**Two-Person**	**Family**
70% - 30% Co-insurance (Dental Included)	☐ $50	☐ $90	☐ $115

Group II: Second Trainer

	Single	**Two-Person**	**Family**
70%-30% Co-insurance (Dental Included)	☐ $150	☐ $280	☐ $340

Group III: Driver/Trainer/Farm/Training Center

	Single	**Two-Person**	**Family**
Option A: 70%-30% Co-insurance (Dental Included)	☐ $200	☐ $370	☐ $400
Option B: 80%-20% Co-insurance (Dental Included)	☐ $250	☐ $463	☐ $568
Option C: 90%-10% Co-insurance (Dental Included)	☐ $330	☐ $568	☐ $750

Group V: Medicare

	Single	**Two-Person**	**Family**
Senior Medical (Dental & Prescription Extra**)**	☐ $100	☐ $200	N/A
Dental & Prescription Coverage	☐ $60	☐ $160	N/A

Signature:	Date: