



SMALL GROUP CHANGE FORM

Use This Form For:

- Notification of terminations of employees/dependents
- COBRA/State Continuation notifications
 - COBRA is for groups of 20 or more employees
 - State Continuation availability varies by state
- Leave of Absence notifications
- Address changes

DO NOT SEND THIS FORM WITH PREMIUM.

Mail Form To:

Illinois:
 UniCare Life & Health Insurance Company
 P.O. Box 5017
 Bolingbrook, IL 60440-5017
 To expedite, fax to:
 (866) 869-2291
 smallgroup.membership@wellpoint.com

All other states:
 UniCare Life & Health Insurance Company
 P.O. Box 5053
 Bolingbrook, IL 60440-5058
 To expedite, fax to:
 (866) 869-2291
 smallgroup.membership@wellpoint.com

Name of Person Completing Form	Signature / Date X	Due Date	Phone No. ()
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1. EMPLOYEES WHO DECLINE COVERAGE

This section is to be completed by newly eligible employees who have declined coverage. Please attach the completed application declining coverage to this form.

Identification No.	Employee Name (Last Name, First Name)	Reason for declining coverage

2. TERMINATING EMPLOYEES

Employees canceling coverage for themselves or their dependent(s) should complete this section. Note: For each terminating employee and/or dependent please elect applicable Federal or State Continuation option. Please refer to the Federal COBRA Guidelines or your State Continuation Guidelines for eligibility. Retroactive terminations by the group are not allowed.

A. Terminating Employees

Identification No.	Employee Name (Last Name, First Name)	Termination Date	Start Federal COBRA (20+ Employees)		Start State Continuation		State Continuation / Federal COBRA Qualifying Event?
			Yes	No	Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

B. Terminating Dependents - **Please provide a completed application for spouse and/or Dependents who are applying for Federal Cobra or State Continuation.**

Employee Identification No.	Dependent Name (Last Name, First Name) Please list eldest first.	Termination Date	Start Federal COBRA (20+ Employees)		Start State Continuation		State Continuation / Federal COBRA Qualifying Event?
			Yes	No	Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

3. EMPLOYEE LEAVE OF ABSENCE

This section should be completed for employees who are beginning a leave of absence.

Identification No.	Employee Name (Last Name, First Name)	MLOA	PLOA	Leave Start Date	Leave End Date

4. EMPLOYEE / GROUP CHANGE OF ADDRESS

This section should be used for group and/or member address changes. Note: The changes MAY result in area band adjustments. Employees moving out of state are not eligible for HMO plans.

A. Employee Change of Address

Identification No.	Employee Name (Last Name, First Name)	New Street Address	City, State, Zip Code

B. Group Change of Address

New Billing Address	New Local Address	City, State, Zip Code

Note: To make additional changes attach request on your company's letterhead. Credit for deletions will appear on the next billing statement. If faxed, please retain fax confirmation.

Insurance coverage underwritten by any of the following: UNICARE Life & Health Insurance Company, UNICARE Health Insurance Company of the Midwest (IL and IN only) or UNICARE Health Plans of the Midwest, Inc. (HMO in IL and IN only) ® Registered Mark of WellPoint Health Networks Inc.