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| **AIARC** | Employee Benefits Change Information | ID card Request (Check for Duplicate or Replacement Card Only)  Vanbreda  MedImpact |  |

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| 1. Center Name  WORLD AGROFORESTRY | | | 2. Center ID Number Insurance Category | | 3. **AIARC use only:**  **JVB  CPAS  MedImpact** | | | |
| 4. Current Employee Name (Last, First, Middle Initial)  Peter K Muraya | | 5. **Change Employee Name To** (Last, First, Middle Initial) | | 6. AIARC ID Number | | 7. Gender  male | | 8. Birthdate  DD MM YYYY  13/2/1960 | |
| 9. **Change** Beneficiary Name(s)  (Last, First, Middle)  Kariuki, Phyllis Njeri | Beneficiary Relationship(s) and date of birth (DD/MM/YYYY)  04/09/1960 | | Relationship  Spouse | Life and AD&D Percentage (%) | | 11. **Employment Date**  DD MM YYYY  1/ 4/ 1985 | | 12. Employee Medicare  Primary Coverage  Yes  No |
| Kariuki, Brian Babu | 11/08/1990 | | Son |  | |
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| Additional Beneficiary Information |  | | | 14. Employment Status | | 15. Misc. | 16. Annual Earnings | |
|  | | | | Active  Retired | |  | U.S. $ | |

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| 17. Effective Date of this  Transaction  DD MM YYYY  **/ /** | 18. Transaction Type (Check One)  Employee Canceling Coverage  Change  Death of Employee  Terminating Employment  Stop Continuation of Coverage  Bridging Coverage  Cancel All Dependent Coverage | Continuation of Health Coverage  Complete this section only if **Transaction Type** is Terminating Employment, Bridging or Death of Employee.  Use Special Remarks Section #22 for additional information.  Continue Employee Health Coverage?  Yes  No  Continue Dependent Health Coverage?  Yes  No |

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| **19. Currently Covered Dependents -** Use this section to **Add, Change** or **Cancel** Dependents (See Instructions on reverse side.) | | | | | | | |
| **Name**  (Last, First, Middle Initial) | **Dependent Address** | **Rel**  **Code** | **Birthdate**  **DD MM YYYY** | **Covered**  **by Other**  **Insurance** | **Medicare**  **Primary**  **Coverage** | **Full**  **Time**  **Student** | **Coverage**  Add Change Cancel |

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| 20. **New Employee Address** (Use for corrections and changes.) |  |
| Street Albert Kaurai Road |  |
|  |
| City Kiserian |
| State/Country Kenya ZIP Code/Postal Code 374-00206 |
| 22. Special Remarks  \_\_\_ |
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| **23.** **Employee Authorization**: I request my coverage be changed as indicated by me above. The provisions as described on the reverse of this form shall be just as effective as if printed here above my signature.  **Fraud Warning Notice:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits a request for enrollment or files a claim containing a false or deceptive statement is guilty of insurance fraud. | |
| **Employee Signature**  Date 24/01/2011 | **Employer Signature**  Date |
|  | Employer Telephone Number (+254 ) - 7224000 |

**AIARC Employee Benefits Change Information**

**Instructions**

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| **NOTE:** *Items 17, 18 and 23 must always be completed. Retain a copy for your file.*  **Items 1-3, 5-16 and 22:** Fill in the appropriate information and use the space provided to make the appropriate changes.  **NOTE**: A change in Beneficiary Designation will not be processed without the **Employee Signature in Item 23.**  **Item 10: Employee Medicare Primary Coverage** **–** Use the following codes to indicate if Medicare is the primary carrier: Y=Yes, N=No.  **Items 13 and 14:** Check the appropriate box.  **Item 17:** Indicate the Effective Date of this transaction.  **Item 18: Transaction Type/Continuance of Health Coverage** – Check the appropriate boxes to indicate Transaction Type and any continuation of health coverage due to BRIDGING. Check Continuation of Health Coverage boxes only if Transaction Type is “Terminating Employment”, “Bridging” or “Death of Employee”.  **Item 19: Currently Covered Dependents**  **To Add** dependent coverage, check the “Add Coverage” box and complete the necessary information under each heading.  **To Change** any information on currently covered dependents, check the “Change Coverage” box and write in new information, including dependent’s name.  **To Cancel** coverage for any dependent, check the “Cancel Coverage” box for that dependent and complete the necessary information. (To cancel coverage for all currently covered dependents, check the “Cancel All Dependent Coverage” box in Item 18.)  **If Adding or Changing** dependent coverage, use the following codes under each heading:  **Rel Code:** H = Husband; W = Wife; N = Divorced Spouse, S = Son; D = Daughter. (If relationship is other than the above, explain in Special Remarks, Item 22.)  **Covered by Other Insurance:** Indicate if the dependent will be enrolled in another group health plan after coverage becomes effective with AIARC. (Y=Yes, N=No)  **Medicare Primary Coverage:** Indicate if Medicare is the primary carrier. (Y=Yes, N=No)  **Full-Time Student:** Indicate if a dependent child 19 – 23 years of age is a Full-Time student. (Y=Yes, N=No)  **Item 20:** Use the space provided to make changes to your mailing address.  **Item 21:** Indicate any changes.  **Item 22: Special Remarks -** Use this section for further explanations concerning any item (i.e., end date of elected coverage).  **Item 23:** Sign and date the form and submit original to your Center’s HR for authorization. |

**Provisions**

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| 1. **Discontinuance Contributions -** I request that deductions of contributions for this coverage be discontinued immediately and understand this coverage will expire at the end of the period covered by my last contribution and that if I request this coverage in the future I must furnish, at my expense, evidence of insurability satisfactory to the Insurance Company for myself (and for eligible dependents if such coverage is requested). 2. **Request Decrease -** Instead of retaining the coverage I now have, I request that it be decreased to conform to my current classification. I understand that this action voids my present certificate and that a new certificate (or Insert) will be issued to reflect this decrease. 3. **Change of Beneficiary -** I revoke all designations of beneficiary and all elections of optional settlement methods previously made by me; and subject to the terms of, and subject to the change as provided in the applicable contract, I designate the beneficiary(ies) indicated on the front of this form. The prior designation has been deleted.   If this Designation of Beneficiary provides for payment to a trustee under a trust agreement, the Insurance Company shall not be obligated to inquire into the terms of the trust agreement and shall not be charged with knowledge of the terms thereof. Payment to and receipt by the trustees shall fully discharge all liability of said Insurance Company to the extent of such payment.  D. **Reclassify Dependents** - I authorize a change in my contributions to conform with my new classification. |