Security Health Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 or 715.221.9555
TTY: 711

Employee Health Insurance Election

Employer name		
Employee name	Social security number	Date of birth (month/day/year) / /

☐ I am not making any changes to my current health insurance coverage.
(Plan selection, demographics (name/address, etc.), family members covered)

☐ I am making changes to my current health insurance coverage.
(*Plan selection, demographics (name/address, etc.), family members covered)*
Complete a Subscriber Health Plan Change Request.

☐ I am newly enrolling on the health insurance coverage.
Complete an Employee Health Insurance Application.

☐ I am waiving coverage.

☐ I am currently enrolled but will be terminating my health insurance coverage as of (m/d/y) ______ /______ /______.
Complete a Subscriber Health Plan Change Request.

Employee signature ____ Date (m/d/y) ______ /______ /______

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