CHANGE OF COVERAGE FORM

PLEASE PRINT 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 Name	M.I.

Social Security #:	Sex: ☐ M ☐ F	Date of Birth:

Address:	City, State, Zip:

Phone #:	Email:

Group I: Groom

	Single	Two-Person	Family
70% - 30% Co-insurance (Dental Included)	☐ $100	☐ $180	☐ $225

Group II: Second Trainer

	Single	Two-Person	Family
70%-30% Co-insurance (Dental Included)	☐ $182	☐ $339	☐ $441

Group III: Driver/Trainer/Farm/Training Center

	Single	Two-Person	Family
Option A: 70%-30% Co-insurance (Dental Included)	☐ $242	☐ $448	☐ $484
Option B: 80%-20% Co-insurance (Dental Included)	☐ $303	☐ $560	☐ $688
Option C: 90%-10% Co-insurance (Dental Included)	☐ $399	☐ $688	☐ $908

Signature:	Date: