EVIDENCE OF GROUP HEALTH COVERAGE

Employee Information

Date:_____/_____/_____

SSN/ID#:_____-_____-_____

Subscriber Name:_____

First Name MI Last Name

Coverage Status

Ending ☐ Beginning ☐

For (check all that apply):

Subscriber ☐ Spouse ☐ Dependent Child(ren) ☐

Name (if other than Subscriber):_____

First Name MI Last Name

_____

Dependent 2 First Name MI Last Name

_____

Dependent 3 First Name MI Last Name

Plan Information

Plan Name: **CEBT**

Plan Administrator: **Willis Towers Watson**

Address: **2000 S. Colorado Blvd. Tower II, Ste. 900 Denver, CO 80222**

Phone: **(303) 773-1373, (800) 332-1168**

Coverage Information

Health Coverage ☐ Dental Coverage ☐ Vision Coverage ☐

End Date:_____/_____/_____ Start Date:_____/_____/_____

Reason for Change:_____