HealthTrust

# NOTICE OF DIVORCE, LEGAL SEPARATION OR DISSOLUTION OF CIVIL UNION

**THIS FORM MUST BE COMPLETED AND SIGNED BY THE ENROLLEE AS NOTIFICATION OF A COURT DECREE REGARDING DIVORCE, LEGAL SEPARATION OR DISSOLUTION OF A CIVIL UNION. HEALTHTRUST MAY REQUEST A COPY OF THE DECREE.**

Enrollee's Name: _____ Date: _____

Enrollee's Mailing Address: _____ Enrollee Date of Birth: _____

Group Name: _____ Group Number: _____

**I hereby notify HealthTrust of the following event affecting my medical and/or dental plan coverage (check one):**

❑ Divorce ❑ Legal Separation ❑ Dissolution of a Civil Union **Date of Decree:** _____

**Former Spouse or Civil Union Partner:** My former spouse or civil union partner was covered as an eligible dependent under my group plan through my employer immediately prior to the issuance of such decree. The decree provides as follows with respect to the nature and payment terms of my former spouse or civil union partner's medical and/or dental plan coverage:

_____

_____

_____

**Children:** The children listed below were covered as eligible dependents under my group plan through my employer immediately prior to the issuance of such decree. The decree provides as follows with respect to these dependent children's medical and/or dental plan coverage:

_____

_____

_____

**I understand that my spouse or former civil union partner and child(ren) may be entitled to continue coverage under my employer's medical and/or dental plan in certain situations pursuant to state or federal law.**

Name of Former Spouse or Civil Union Partner: _____

Current Mailing Address: _____

Date of Birth: _____

Employer/Employment Status: _____

| Name(s) of covered child(ren) | Date(s) of Birth | Address |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

_____

Enrollee Signature Date