NOTICE OF DIVORCE OR LEGAL SEPARATION

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

Enrollee Name: ______________________ **Date:** ______________________

Enrollee Mailing Address: ______________________ **Enrollee Date of Birth:** ______________________

Group Name: ______________________

I hereby notify HealthTrust of the following event affecting my medical and/or dental plan coverage (check one): ☐ Divorce ☐ Legal Separation **Date of Decree:** ______________________

Former Spouse: My former spouse 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's medical and/or dental plan coverage:

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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:

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I understand that my former spouse 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.

______________________ ______________________

Enrollee Signature **Date**

Name of Former Spouse: ______________________

Date of Birth: ______________________

Current Mailing Address: ______________________

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