Department of HUMAN SERVICES

# Change in Health Insurance

Date:
County:
Worker Number:
Worker Name:
Phone:

Worker E-mail:
Information is due by:

Dear

A change in your health insurance has been reported.

Please fill out the attached *Insurance Questionnaire* and return it to us:

**Your household's benefits may stop if you don't give the information by the due date above.**

Call my office if:

- You have questions or need help.
- You can't get the information I need by the due date above, or
- You need this information in another language.

I accept collect calls.

Thank you for your cooperation.

Income Maintenance Worker