



MEMBER CHANGE FORM

Membership Department
P.O. Box 890172
Camp Hill, PA 17089

In order to process this Change Form, the name and Member Identification Number of the Employee/Contract Holder must be completed in the space provided.

1. Employer Name _____

2. Employee Telephone Number () _____

3. Association Name (if applicable) _____

4. Group Number _____

5. Employee (Last) _____

6. Member Identification Number _____

7-9 Please check the changes that you need to make to your member records:

Change PCP Change Report Code Change Contract type to (check new contract type) Change Enrollment Status to

Change of Name Existing: _____ New: _____ POS Comp. MM Vision Single Parent/Children

Change of Address Add Spouse/Dependent(s) PPO FA PR Drug Insured & Spouse/Domestic Partner

Change of Phone Change Spouse/Dependent Status Product Name: _____ Parent/Child Family

Change Birthdate Existing: _____ New: _____ Delete Spouse/Dependent(s)

Change Hire Date _____

10. Effective Date of Change _____

11. Please give a brief description of the changes to be made.

COMPLETE ONLY THE SECTIONS THAT APPLY TO CHANGES IN MEMBER RECORDS.

12. Street Address _____ City _____ State _____ Zip Code _____ Home Phone () _____ Work Phone () _____

13. Employee/Contract Holder

Add Change Spouse/Domestic Partner

Terminate (indicate reason for termination) Add Change

Deceased Married Divorced Deceased Terminated (indicate reason for termination)

Request Cancel Medicare Request Cancel Divorced Deceased Married Divorced Deceased Terminated (indicate reason for termination)

Request Cancel Medicare Request Cancel Divorced Deceased Married Divorced Deceased Terminated (indicate reason for termination)

14. Spouse/Domestic Partner

Add Change Spouse/Domestic Partner

Terminate (indicate reason for termination) Add Change

Deceased Married Divorced Deceased Terminated (indicate reason for termination)

Request Cancel Medicare Request Cancel Divorced Deceased Married Divorced Deceased Terminated (indicate reason for termination)

15. Dependent

Add Change Spouse/Domestic Partner

Terminate (indicate reason for termination) Add Change

Deceased Married Divorced Deceased Terminated (indicate reason for termination)

Request Cancel Medicare Request Cancel Divorced Deceased Married Divorced Deceased Terminated (indicate reason for termination)

16. Type of Change

Add Change Spouse/Domestic Partner

Terminate (indicate reason for termination) Add Change

Deceased Married Divorced Deceased Terminated (indicate reason for termination)

Request Cancel Medicare Request Cancel Divorced Deceased Married Divorced Deceased Terminated (indicate reason for termination)

17. Previous Member Identification Number _____

18. Current Member Identification Number _____

19. Previous Last Name _____

20. Current Last Name _____

21. First Name Middle Initial _____

22. Sex Male Female

23. Member Status Male Female

(20) Employee Spouse Domestic Partner Child Student Grandchild Niece Stepchild Disabled Nephew Grandchild Niece Stepchild Deceased Nephew Grandchild Niece Stepchild

If your group provides coverage for "Domestic Partner" or "Other", please check the appropriate blue box.

24. Birthdate _____

25. Primary Care Physician Name _____

26. Primary Care Physician Number _____

27. Existing Patient? Yes No

28. Marriage Date _____

Please check one if applicable (if additional space is required, attach a separate sheet). If you your spouse/domestic partner or dependent(s) are enrolled in another Program or Medicare, please give the following information:

Group No: _____ Name of Insurance Carrier: _____

Name of insured: _____ Identification Number: _____

IMPORTANT: PLEASE READ AND SIGN BELOW: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

29. Employee's Signature and Date _____

Authorization Employer's Signature and Date _____