Member Change Form

Employer Name: Group #: Division #: Policy Code:

Coverage Affected: ☐ Medical ☐ Dental ☐ Both Effective Date of Change: / /

Employee Information/Changes

Last Name	First Name		Middle Initial
Street Address	City	State	Zip
Social Security Number	Date of Birth / /	Gender	Group Health Cooperative ID Number
Home Phone	Daytime Phone		Cell Phone

☐ **Cancel all coverage (employee and any dependents)** – Reason:
☐ **Name change** – Previous name:
☐ **New address** – Previous address:
☐ **New phone number** – Previous phone number:

Dependent Changes

REASON and DATE

☐ Marriage: / / ☐ Birth: / / ☐ Lost other Coverage*: / / ☐ Divorce: / /
☐ Adoption: / / ☐ Death: / / ☐ New Dependent: / / ☐ Other (Describe):

Add	Remove	Last Name	First Name	MI	Date of Birth	Gender	Smoker? (Y or N)	Relationship to Employee	Social Security Number
☐	☐				/ /				
☐	☐				/ /				
☐	☐				/ /				

* **Attach Certificate of Creditable Coverage**

Other Changes

☐ Change from active employee to state continuation/federal COBRA effective: / /
(Please attach a copy of signed member continuation form.)

☐ Change from eligible dependent to state continuation/federal COBRA effective: / /
(Please attach a copy of signed member continuation form)

☐ Eligible for Medicare coverage (attach copy of Medicare ID card):
Name: Medicare Card #: Part A Effective Date: / / Part B Effective Date: / /
Reason: ☐ Age 65 or older ☐ Disability ☐ End Stage Renal Disease – onset date: / /

☐ Other:

Other Insurance Information

Does anyone named in this application have other group insurance coverage? ☐ **Yes** ☐ **No**
If yes, who?
a. Type of Coverage: ☐ Medical ☐ Dental ☐ HIRSP b. Effective Date: / / Cancel Date: / /

Employee Signature_____ Date _____