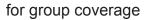
## **Change Form**







Section 1 – Member Information (complet	tion of this	s section is required)	
$\square$ Check this box if member information has ch	anged.		
		Gender □ Male □ Female	e
First Name	MI		Date of Birth
Last Name	Suffix	Social Security Number	
Residential Address		Home Phone Number	Cell Phone Number
City		E-mail Address	
State ZIP Code +4 County		Employed by	
Mailing Address (if different from residential address)		Work Phone Number	Fax Number
City		Group Number	
State ZIP Code +4 County		Member ID Number	
Section 2 – Adding Family Members to Co	overage		
I want to enroll in:	<u> </u>		
Employee only ☐ Health ☐ Den	tal	Employee and spouse	☐ Health ☐ Dental
Employee and child(ren) $\square$ Health $\square$ Den	tal	Employee and family	☐ Health ☐ Dental
<b>Reason for change:</b> ☐ Birth/adoption ☐ Ma	arriage [	☐ Divorce ☐ Open Enrollme	nt
	•	e reason):	
Official Date of Occurrence		anne tha fallentine encations fo	on a calle da manada est (a calle 24
Important – Tobacco Use (BlueCare policies and over).	only): An	swer the following questions to	r each dependent (age 21
Have any of your dependents used any tobaccocigars, smokeless tobacco, etc., on average 4 or religious or ceremonial use?	•		• •
If yes, does your dependent agree to participat	e in and co	omplete our cessation program	1?
Relationship to member:   Spouse   Child	☐ Step	child	☐ Legal Custody
First Name	MI	Gender ☐ Male ☐ Female	e
Last Name	Suffix	Social Security Number	Date of Marriage/Adoption
Tobacco Use: ☐ Yes	s 🗆 No	Cessation Program:	☐ Yes ☐ No
Relationship to member:   Spouse   Child	☐ Step	child	☐ Legal Custody
First Name	MI	Gender ☐ Male ☐ Female	e Date of Birth
Last Name	Suffix	Social Security Number	Date of Marriage/Adoption
Tobacco Use:		Cessation Program:	☐ Yes ☐ No

Section 2 – Adding Family Members to Cov	erage (	continued)	
Relationship to member:   Spouse   Child	☐ Step	child	☐ Legal Custody
First Name		Gender ☐ Male ☐ Female	Date of Birth
Last Name	Suffix	Social Security Number	Date of Marriage/Adoption
Tobacco Use: ☐ Yes	□No	Cessation Program:	☐ Yes ☐ No
Are you or any of your listed dependents cove	ered by	Medicare Part A and/or B?	☐ Yes ☐ No
Name of family member with coverage:			
First Name	MI	Medicare ID Number	
Last Name	Suffix	Part A Effective Date	Part B Effective Date
Are you entitled to Medicare due to ESRD (perma	anent kid	lney failure)?	☐ Yes ☐ No
Is anyone enrolling in this coverage entitled to other group insurance (excluding Medicare, M		•	tal expenses from any ☐ Yes ☐ No
Section 3 – Removing Family Members from Check one:  ☐ Change to employee only ☐ Change to emp ☐ Retain family and terminate coverage for:	loyee ar	_	oyee and child(ren)
Reason for change:  Divorce Child reaching age limit Dea  Official Date of Occurrence  Relationship to member: Spouse Child	ith □	Other (give reason):	☐ Legal Custody
First Name		Gender ☐ Male ☐ Female	Date of Birth
Last Name	Suffix	Social Security Number	
Relationship to member:   Spouse   Child	☐ Step	child	☐ Legal Custody
First Name		Gender ☐ Male ☐ Female	Date of Birth
Last Name	Suffix	Social Security Number	
Section 4 – Other Changes and Comments  I represent that all statements made herein are complet any material information or if I intentionally misrepresent result in the re-rating, termination or rescission of my here.	e and tru t any mat ealth care	terial fact, such omission or intention	al misrepresentation may
To process the above changes, please sign and date Your signature required	€.		
Member			Date Signed
Signature of Plan Administrator			Date Signed