MEMBER CHANGE FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY IN BLUE OR BLACK INK. DO NOT USE PENCIL OR HIGHLIGHTER.

EMPLOYEE/CONTRACT HOLDER INFORMATION

Effective Date	Employer/Group Name	Group Number	Payroll Location

REASON FOR COMPLETION:

❑ Enrollment Changes

❑ Cancel Entire Contract

❑ COBRA Continuant

Start Date _____

(Please attach a copy of COBRA Election Notice.)

DEPENDENT CHANGES:

Add dependent(s) due to HIPAA Life Event:

❑ Birth ❑ Marriage ❑ Adoption ❑ Other _____

Date of Above Event _____

(Please attach a copy of HIPAA Certification Form, if applicable.)

❑ Add Act 4 Dependent

Cancel dependents due to:

❑ Divorce ❑ Death ❑ Other _____

Date of Above Event _____

OTHER CHANGES:

❑ New Name

❑ New Address

❑ Change to Medicare Eligible

❑ Change Coverage

Date of Above Event

_____

CANCEL Reason for Contract Holder:

❑ Deceased ❑ Left Employment ❑ Involuntary Lay-Off ❑ Other Coverage ❑ Other _____ Date of Above Event _____

Additional Comments:

First Name	MI	Last Name	Home/Cell Phone

Address	City	State	Zip	County

Date of Birth *(Month/Day/Year)*	Age	Gender	Employment Status	Social Security Number *(If no SS#, write N/A)*
/ /		❑ Male ❑ Female	❑ Active ❑ COBRA ❑ Disabled	

Requested Products

❑ Medical Product Name: _____ ❑ Vision ❑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
		❑ Yes ❑ No

COVERED DEPENDENT INFORMATION (If additional space is required, attach a separate sheet)

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You?
			❑ Spouse ❑ Domestic Partner†

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age
	❑ Male ❑ Female	/ /	

Product Selection(s)

❑ Medical ❑ Vision ❑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Spouse/DP an Established Patient?
		❑ Yes ❑ No

Note: If spouse's last name differs from the contract holder above, please attach a copy of your marriage license.

†If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and financial verification documents to this application.

DEPENDENT CHILD #1

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Adopted* ❑ Other*

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age
	❑ Male ❑ Female	/ /	

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Child an Established Patient?
		❑ Yes ❑ No

If Over Age 25, is Dependent Disabled?	Product Selection(s)
❑ Yes ❑ No	❑ Medical ❑ Vision ❑ Dental

DEPENDENT CHILD #2

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Adopted* ❑ Other*
Social Security Number *(If no SS#, write N/A)*		Gender ❑ Male ❑ Female	Date of Birth *(Month/Day/Year)* / / Age
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? ❑ Yes ❑ No
If Over Age 25, is Dependent Disabled? ❑ Yes ❑ No		Product Selection(s) ❑ Medical ❑ Vision ❑ Dental	

DEPENDENT CHILD #3

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Adopted* ❑ Other*
Social Security Number *(If no SS#, write N/A)*		Gender ❑ Male ❑ Female	Date of Birth *(Month/Day/Year)* / / Age
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? ❑ Yes ❑ No
If Over Age 25, is Dependent Disabled? ❑ Yes ❑ No		Product Selection(s) ❑ Medical ❑ Vision ❑ Dental	

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custody/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, an Act 4 Dependent Verification Form must also be completed.

OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date / /	Name of Policyholder
Policyholder Date of Birth / /	Relationship to Policyholder	Policy Number	Policyholder Employment Status ❑ Active ❑ Retired Date of Retirement: / /

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								❑ Yes ❑ No
								❑ Yes ❑ No
								❑ Yes ❑ No

IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered. To the best of my knowledge and belief, the information provided on this application is true and correct.

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.

Employee/Contract Holder Signature _____ Date _____

Please fax Member Change Forms to (800) 290-3301 or mail the forms to one of the following addresses:

https://www.enrollmentandbilling@highmark.com

Membership Department
P.O. Box 535193
Pittsburgh, PA 15253-5193