

Subscriber

Change Request

		Employer name	Effective date _____
Subscriber last name	First name	MI	Subscriber number
Spouse's last name	Spouse's first name	MI	Group number
Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Separated			

Check and complete changes that apply and sign below.

<input type="checkbox"/> Name change	Change from	Change to	Reason for change	
	If married, spouse's name		Date of marriage (m/d/y) / /	Date of divorce (m/d/y) <i>If applicable</i> / /
<input type="checkbox"/> Phone number change	Change to ()		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
<input type="checkbox"/> Email address change	Change to			
<input type="checkbox"/> Address change	Street/Route			Apartment number
	City		State	ZIP code
Change <input type="checkbox"/> Residence address applies to: <input type="checkbox"/> Mailing address		County		
<input type="checkbox"/> Primary care provider	Name (first and last)		Facility/Clinic location where primary care is received	
<input type="checkbox"/> Plan change	Group number	Plan description		
<input type="checkbox"/> Cancel employer group subscriber coverage	Cancellation date (m/d/y) <i>List first date of ineligibility requested</i> / /			
	Reason cancelled			
<input type="checkbox"/> Cancel an individual policy	Requested cancellation date (m/d/y) / /			

Addition of spouse or dependent(s)

Note to Select subscribers: If you are adding a spouse, your spouse will need to complete an *Application for Individual Medical Insurance*. Adding or deleting a spouse or dependent will increase or decrease your current monthly premium. Include a check or money order for the additional premium needed to add a spouse or dependent(s).

Name				Gender			Date of Birth			Relationship to Subscriber	Social Security Number				Office Use Only
Last	Former Last/Maiden	First	MI	M	F	Mo	Day	Yr					Member Identifier		
Primary care provider name (first and last)										Facility/Clinic location where primary care is received					
Primary care provider name (first and last)										Facility/Clinic location where primary care is received					

Date added ___ / ___ / ___ Reason added _____

Deletion of dependent(s)

Name				Date of Birth			Termination Date	Office Use Only
Last	First	MI	Mo	Day	Yr	Member Identifier		

Reason deleted _____

Subscriber signature _____ **Date (m/d/y)** ___ / ___ / ___
(Signature required for any change)