



CHANGE FORM

Subscriber Name (as listed on insurance card) <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried						Group ID #	
Subscriber ID #						Group Name	
A. ADD COVERAGE							Effective Date:
Name	PCP Choice	DOB	Social Security #	Sex	Tobacco User?		mm-dd-year
<input type="checkbox"/> Newborn:				M F	Yes	No	
<input type="checkbox"/> Dep. Child:							
<input type="checkbox"/> Spouse:							
<input type="checkbox"/> Coverage due to termination of spouse's benefits (Attach termination letter from employer or insurer)			Does spouse's employer offer Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Insurer:				
B. TERMINATION / DROP COVERAGE							Effective Date:
<input type="checkbox"/> Termination date for <input type="checkbox"/> employee <input type="checkbox"/> dependent: Reason: <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary							
<input type="checkbox"/> COBRA termination date:							
<input type="checkbox"/> Divorce				Date of Divorce (Attach Divorce Decree):			
<input type="checkbox"/> Dependent no longer full-time student, Name:					Last Date Attending School:		
<input type="checkbox"/> New coverage through spouse and/or dependent (Attach letter from employer or insurer)							
<input type="checkbox"/> Death							
C. COVERAGE CONTINUATION ELECTION							Effective Date:
<input type="checkbox"/> Plan continuation Provision (90 day per GA law, for groups with <20 members)							
<input type="checkbox"/> Individual Conversion Policy (Information will be sent)							
<input type="checkbox"/> COBRA: <input type="checkbox"/> Month to Month <input type="checkbox"/> 18 month duration			Date Cobra Activated:				
Continue for: <input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent (s): (1)							
(2)		(3)		(4)			
D. CONSUMER CHOICE OPTION (Please attach CCO Form)							Effective Date:
<input type="checkbox"/> I elect to participate in the Consumer Choice Option.				<input type="checkbox"/> I no longer elect to participate in the Consumer Choice Option.			
Nominated Provider:				(Please Indicate plan choice in section G.)			
E. PRIMARY CARE PHYSICIAN CHANGE							Effective Date:
Member Name:			Physician Name:				
F. NAME / ADDRESS / PHONE CHANGE							Effective Date:
New Name:			New Phone:				
New Address:							
G. PLAN CHOICE CHANGE							Effective Date:
<input type="checkbox"/> HMO:				<input type="checkbox"/> POS:			
<input type="checkbox"/> HSA				<input type="checkbox"/> Dental:			
H. COVERAGE TIER CHANGE							Effective Date:
Current: <input type="checkbox"/> Employee Only <input type="checkbox"/> EE + Spouse			New: <input type="checkbox"/> Employee Only <input type="checkbox"/> EE + Spouse				
<input type="checkbox"/> EE + Child <input type="checkbox"/> Family			<input type="checkbox"/> EE + Child <input type="checkbox"/> Family				
Employee Signature:			Date:		Employer Signature:		Date: