Change Form

PO Box 205 • Grand Rapids, MI 49501-0205

(Member changes must be received by Priority Health within 31 days of the event.)

SECTION 1 - EMPLOYEE INFORMATION

Employee's Last Name	First Name	Middle Initial	Social Security Number
			— —

SECTION 2 - CHANGES (Please complete only those changes which apply.)

☐ ADDRESS/PHONE CHANGE	Street Address		City
State	Zip Code	Home Phone ( ) -	Work Phone ( ) -

☐ NAME CHANGE	New Last Name	Former Last Name

☐ **DEPENDENT CHANGE** (If you have more than 4 dependent changes please complete an additional change form).

Date Change Occurred / /

Reason for Change Add ☐ Delete ☐

#	Last Name		First Name	Middle Initial	Social Security Number
1	Birth Date / /	Sex Male ☐ Female ☐	Relation to Employee	Primary Care Provider **(REQUIRED for HMO & POS)**	
	Has this dependent ever seen this provider? Yes ☐ No ☐	PCP Address/ID Code			
2	Last Name		First Name	Middle Initial	Social Security Number
	Birth Date / /	Sex Male ☐ Female ☐	Relation to Employee	Primary Care Provider **(REQUIRED for HMO & POS)**	
	Has this dependent ever seen this provider? Yes ☐ No ☐	PCP Address/ID Code			
3	Last Name		First Name	Middle Initial	Social Security Number
	Birth Date / /	Sex Male ☐ Female ☐	Relation to Employee	Primary Care Provider **(REQUIRED for HMO & POS)**	
	Has this dependent ever seen this provider? Yes ☐ No ☐	PCP Address/ID Code			
4	Last Name		First Name	Middle Initial	Social Security Number
	Birth Date / /	Sex Male ☐ Female ☐	Relation to Employee	Primary Care Provider **(REQUIRED for HMO & POS)**	
	Has this dependent ever seen this provider? Yes ☐ No ☐	PCP Address/ID Code			

If you, or your spouse, or any dependents are covered by Medicare or any other insurance policy providing medical benefits, please complete this section.

WHERE ARE CLAIMS SENT?	Company Name		Company Address	
POLICYHOLDER INFORMATION	Name of Policyholder	Birthdate / /	Policy Effective Date / /	Employer
	Family Member(s) Covered (1) (2) (3) (4)			
REASON FOR MEDICARE	End Stage Renal Disease ☐ Disabled ☐ Over Age 65 ☐ Over Age 65 and Working ☐			Effective Date / /

SECTION 3 - AUTHORIZATION

I authorize Priority Health to make the changes indicated above for me and my dependents. I understand that Priority Health may request pertinent sworn statements if needed and that I must sign and date this form before it will be processed.

Priority Health requires proper handling of personal health information for our members. Details of our confidentiality policies and procedures are available upon request.

X ____

Employee Signature Date

Employer Name	Group Number	Sub Group Number	Class
Employer/Representative Signature			Date / /

Plan Change ☐ (If checked, please also check one of the following) HMO ☐ POS ☐ PPO ☐ HBC ☐ HRA ☐ HSA ☐
Plan Option (if applicable) High ☐ Mid ☐ Low ☐

REASONS FOR ADDITIONS
Marriage ☐ Birth ☐ Adoption ☐ Divorce ☐ Death ☐ Lost Eligibility ☐ Loss of other coverage (Proof Required) ☐ Other ________
Effective Date / /

REASONS FOR DELETIONS
Marriage of Dependent ☐ Divorce ☐ Death ☐ Lost Eligibility ☐ Other ☐ ________________
Date Coverage Ended / /

REASON FOR TERMINATION OF ENTIRE CONTRACT
Terminated Employment ☐ Lay Off ☐ Leave of Absence ☐ Changed Health Plans ☐ Moved out of area ☐
Death ☐ COBRA Terminated ☐ Dissatisfied ☐ Other ☐ ________________
Date Occurred / / Date Coverage Ended / /

For Priority Health Use Only	Date Received / /	Processor	Code	Date Processed

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