



## MEMBER STATUS CHANGE REQUEST

Complete only if **presently insured** by Capital Health Plan.

**Changes must be made within defined eligibility period. If a Member's name changes because of divorce or remarriage, other carrier liability section must be completed.**

### THE BACK OF THIS FORM MUST BE COMPLETED

#### I. GENERAL INFORMATION

<b>1. Name of Group Employer:</b>	<b>2. Group #:</b>
<b>3. Contract Holder's Name (Last, First, MI):</b>	<b>4. CHP ID #:</b>

<b>5. TYPE OF CHANGE:</b> <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Add Dependent <input type="checkbox"/> Cancel Dependent <input type="checkbox"/> Cancel Coverage <input type="checkbox"/> Other _____  <b>Effective Date of Change:</b> _____	<b>6. TYPE COVERAGE REQUESTED:</b> <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse* <input type="checkbox"/> Employee/Child* <input type="checkbox"/> Employee/Family  <small>* Only available when offered.</small>	<b>7. REASON FOR CHANGE:</b> <input type="checkbox"/> Marriage** <input checked="" type="checkbox"/> <input type="checkbox"/> Death** <input type="checkbox"/> Terminate Employment** <input type="checkbox"/> Divorce** <input checked="" type="checkbox"/> <input type="checkbox"/> Birth** <input type="checkbox"/> Adoption** <input checked="" type="checkbox"/>  <b>** Date of Event</b> _____ <input checked="" type="checkbox"/> <b>Supporting documentation required.</b>
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#### II. ADDITIONS OF ELIGIBLE FAMILY MEMBERS TO BE COVERED: *(Attach supporting documentation when required.)* PLEASE PRINT. If more space is required, attach a separate sheet.

		8. Name (Last, First, MI)	9. Social Security Number	10. Relation- ship	11. Date of Birth	12. Disabled	14. Primary Care Physician (First Initial and Last Name)	15. Current Patient	For non-spousal dependents (ages 19-26) enrolling in grandfathered plans <sup>+</sup> , please complete the Dependent Eligibility Attestation.
<b>ADDITIONS</b>	Add Spouse	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Add Dependent Child	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> My Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other <input checked="" type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Add Dependent Child	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> My Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other <input checked="" type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Add Dependent Child	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> My Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other <input checked="" type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Add Dependent	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> My Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other <input checked="" type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>15. Please provide (on the reverse side of this form) an alternate address for any dependent not living with you.</b>									

#### III. DELETIONS AND/OR CHANGES TO COVERAGE

<b>DELETIONS</b>	16. Name	17. Date of Birth	18. Name	19. Date of Birth	
	20. Name	21. Date of Birth	22. Name	23. Date of Birth	
<b>24. Reason for Deletion:</b> <input type="checkbox"/> Age <input type="checkbox"/> Divorce <input type="checkbox"/> Marriage <input type="checkbox"/> Death <input type="checkbox"/> Other – Please explain:					
<b>CHANGES</b>	25. <input type="checkbox"/> <b>Address Change</b>	26. New address:			27. Telephone Number:
	28. <input type="checkbox"/> <b>Name Change</b> <input checked="" type="checkbox"/>	29. Change Name From: _____ To: _____			
	30. <input type="checkbox"/> <b>Other</b>				

<sup>+</sup>Grandfathered plans are employer groups with an original effective date before March 23, 2010 that renew with no material benefit changes on or after March 23, 2010. If you are unsure whether you are enrolled in a grandfathered plan or not, please contact Capital Health Plan at 850-383-3311 or contact your Human Resources department.

