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:

❑ Changes ❑ Cancel Entire Contract

❑ COBRA Continuant

Start Date _____

(Please attach a copy of COBRA Election Notice.)

DEPENDENT CHANGES:

Add dependents due to:

❑ Birth ❑ Marriage ❑ Adoption ❑ Act 4 Dependent

Date of Above Event _____

Cancel dependents due to:

❑ Divorce ❑ Death ❑ Other _____

Date of Above Event _____

OTHER CHANGES:

❑ New Name

❑ New Address

❑ Change to Medicare Eligible

❑ Change Coverage

❑ HIPAA Life Event *(Please attach a copy of HIPAA Certification Form.)*

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

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months?*** ❑ Yes ❑ No

If "Yes," when was the last time you used tobacco regularly? ____/____/____ *(Month/Day/Year)*

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	/ /	

Requested Products	Has the dependent smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months?*** ❑ Yes ❑ No If "Yes," when was the last time the dependent used tobacco regularly? ____/____/____ *(Month/Day/Year)*
❑ Medical ❑ Vision ❑ Dental	

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	Dependent Status if over Age 26
	❑ Male ❑ Female	/ /		❑ Disabled ❑ Act 4**

Requested Products	Has the dependent smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months?*** ❑ Yes ❑ No If "Yes," when was the last time the dependent used tobacco regularly? ____/____/____ *(Month/Day/Year)*
❑ 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.

***Not applicable to members under age 21.

DEPENDENT CHILD #2

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

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age	Dependent Status if over Age 26
	❑ Male ❑ Female	/ /		❑ Disabled ❑ Act 4**

Requested Products	Has the dependent smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months?*** ❑ Yes ❑ No If "Yes," when was the last time the dependent used tobacco regularly? / / *(Month/Day/Year)*
❑ Medical ❑ Vision ❑ Dental	

DEPENDENT CHILD #3

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

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age	Dependent Status if over Age 26
	❑ Male ❑ Female	/ /		❑ Disabled ❑ Act 4**

Requested Products	Has the dependent smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months?*** ❑ Yes ❑ No If "Yes," when was the last time the dependent used tobacco regularly? / / *(Month/Day/Year)*
❑ 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.

***Not applicable to members under age 21.

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