



# MEMBER CHANGE FORM

Please complete this form when making enrollment changes to your CHA Health plan and return to your insurance coordinator when complete.

		EMPLOYEE INFORMATION
<b>1</b>	Today's Date: _____	Requested Effective Date of Change: _____
	Person Completing Form: _____	Employee Name : _____
	<b>Reason for Change:</b> <input type="checkbox"/> Terminate Dep Coverage <input type="checkbox"/> Name/Address Change <input type="checkbox"/> COBRA Election <input type="checkbox"/> Benefit Plan Change <input type="checkbox"/> Add Dependent <input type="checkbox"/> Terminate All Coverage <input type="checkbox"/> Other : _____	Employee Number: _____  Group Name : _____ Group Number: _____

ADDITIONS & TERMINATIONS						
<b>Additions</b>			<b>Terminations</b>			
<input type="checkbox"/> Birth: (date) _____	<input type="checkbox"/> Marriage*: (date) _____		<input type="checkbox"/> Ineligible Dependent	<input type="checkbox"/> Divorce: (date) _____		
<input type="checkbox"/> Adoption: (date) _____	<input type="checkbox"/> Other*: (date) _____		<input type="checkbox"/> Student Age Limit	<input type="checkbox"/> Death: (date) _____		
<input type="checkbox"/> Reinstatement: (reason & date) _____			<input type="checkbox"/> Left Employment: (date) _____			
<input type="checkbox"/> Open Enrollment: _____			<input type="checkbox"/> Open Enrollment: _____			
(All new members are encouraged to select a Primary Care Physician - except if they have a PPO plan)						
<b>2</b>	<b>Full Name</b>	<b>Birth Date</b>	<b>Gender M/F</b>	<b>Relationship</b>	<b>Social Security Number</b>	<b>Primary Care Physician</b>

EFFECT ON PREMIUM				
<b>3</b>	<input type="checkbox"/> Employee to Couple	<input type="checkbox"/> Couple to Employee	<input type="checkbox"/> Employee/Child(ren) to Employee	<input type="checkbox"/> Family to Employee
	<input type="checkbox"/> Employee to Employee/Child(ren)	<input type="checkbox"/> Couple to Employee/Child(ren)	<input type="checkbox"/> Employee/Child(ren) to Couple	<input type="checkbox"/> Family to Couple
	<input type="checkbox"/> Employee to Family	<input type="checkbox"/> Couple to Family	<input type="checkbox"/> Employee/Child(ren) to Family	<input type="checkbox"/> Family to Employee/Child (ren)
	<input type="checkbox"/> No Change			

INDICATE CHANGE REQUESTED		TO
<b>4</b>	<input type="checkbox"/> Name Change	
	<input type="checkbox"/> Address Change	
	<input type="checkbox"/> Email Address Change	
	<input type="checkbox"/> Primary Care Physician (member)	
	<input type="checkbox"/> Primary Care Physician (dependent)	
	<input type="checkbox"/> COBRA Election	
	<input type="checkbox"/> Benefit Change	

CHA Health, PO Box 23468, Lexington, KY 40523-3468

\* Prior Coverage: In order to give you credit towards the pre-existing condition exclusion, list all health insurance coverage this dependent has had for the past 12 months. Attach the "Creditable Coverage Certificate" from the prior insurer for each dependent listed.