

CHANGE/CANCELLATION FORM

Please complete applicable sections, including your signature.
Use blue or black ink only, and be sure all copies are legible.



Check box if applicable and complete corresponding section	Subscriber's Last Name: _____ First Name: _____ M.I.: _____		PHS ID #: _____		Business Phone #: _____		Extension: _____			
<input type="checkbox"/> Change Address	New Address: _____ Street: _____ City: _____ State: _____ Zip: _____		New Home Phone #: _____							
<input type="checkbox"/> Change Name	Old Name: _____			New Name: _____						
<input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Change Primary Care Physician	Term Code*:	Relationship to You:	Last Name:	First Name:	M.I.:	Social Security #:	Sex M F	Date of Birth: MO DAY YR	Name of Primary Care Physician:	Access Number:
						_____		__ / __ / __		_____
						_____		__ / __ / __		_____
Reason for addition or deletion, if not open enrollment: Birth <input type="checkbox"/> Birth Date: ____/____/____ Adoption <input type="checkbox"/> Adoption Date: ____/____/____ Marriage <input type="checkbox"/> Marriage Date: ____/____/____ Divorce <input type="checkbox"/> Divorce Date: ____/____/____ Other: _____ Date: ____/____/____										
<input type="checkbox"/> Indicate Subscriber/Dependent Who Has Other Coverage:	Is your spouse employed? If yes, list employer's name and address: _____ YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, list spouse's business phone: _____									
	Are your dependents covered by other health insurance?: YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, list other health insurance company and policy number: _____					Please list names of family members, including yourself, who are eligible for Medicare: List those who are disabled:				
<input type="checkbox"/> Terminate Contract (Subscriber & Dependents)	Term Code*: _____ (Required - See term codes in box at right)									
<input type="checkbox"/> Reinstate Contract (Subscriber & Dependents)	Reason for Reinstatement: _____									
<input type="checkbox"/> Transfer Contract (Subscriber & Dependents)	From: Group Number _____ To: Group Number _____									
	From: Sub Group #: _____ To: Sub Group #: _____									
	From Plan #: _____ To Plan #: _____ Effective Date: _____									
<input type="checkbox"/> Other										
<input type="checkbox"/> Subscriber's Signature	Signature: _____					Date: _____				
EMPLOYER INFORMATION	Effective Date of Change/Cancel:		Group #:	Subgroup:	Plan Code:	Employer Name:		Employer Signature:		Date:
	MO	DAY	YR							

***TERM CODES (use for deleting dependents or contract)**

A - Left employment/change of employment status
 B - Deceased
 C - Retired
 D - Transferred to another insurance
 E - Moved out of area
 N - Divorced
 T - Dependent Ineligible
 V - Termination of continuation options (COBRA or state extension)
 X - Laid off