



Capital Health
P L A N

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

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

5. TYPE OF CHANGE: <input type="checkbox"/> Change to COBRA <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 _____ Effective Date of Change: _____	6. TYPE COVERAGE REQUESTED: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse* <input type="checkbox"/> Employee/Child* <input type="checkbox"/> Employee/Family * Only available when offered.	7. REASON FOR CHANGE: <input type="checkbox"/> Marriage** <input checked="" type="checkbox"/> <input type="checkbox"/> Death** <input type="checkbox"/> Terminate <input type="checkbox"/> Employment** <input type="checkbox"/> Divorce** <input checked="" type="checkbox"/> <input type="checkbox"/> Birth** <input type="checkbox"/> Adoption** <input checked="" type="checkbox"/> ** Date of Event _____ <input checked="" type="checkbox"/> Supporting documentation required.	<input type="checkbox"/> Overage Dependent <input type="checkbox"/> Moved from Service Area** <input type="checkbox"/> Leave of Absence/Layoff** <input type="checkbox"/> Other Insurance <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other _____
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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.

ADDITIONS	8. Name (Last, First, MI)		9. Social Security Number	10. Relationship	11. Date of Birth	12. Disabled	13. Check if:			14. Primary Care Physician (First Initial and Last Name)	15. Current Patient
	Add Spouse	<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	Supported By You	Living With You	Full-Time/Part-Time Student		<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

15. Please provide (on the reverse side of this form) an alternate address for any dependent not living with you.

III. DELETIONS AND/OR CHANGES TO COVERAGE

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

IV. OTHER CARRIER LIABILITY INFORMATION – THIS SECTION MUST BE COMPLETED.

On the day this coverage begins, will you or any family members enrolling in this plan be covered by any other group or individual health insurance or Medicare? Yes No **If yes**, fill out the appropriate section(s) on the back. If more space is required, attach a separate sheet.

31. <input type="checkbox"/> Health		32. <input type="checkbox"/> Additional Health or <input type="checkbox"/> Dental		33. <input type="checkbox"/> Medicare	
Insured's/Member's Name	Date of Birth	Insured's/Member's Name	Date of Birth	Beneficiary Name	Beneficiary Name
Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired		Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired		Entitlement Reason:	Entitlement Reason:
Name of Employer:		Name of Employer:		<input type="checkbox"/> Age 65 or older	<input type="checkbox"/> Age 65 or older
Policy #	Effective Date:	Policy #	Effective Date:	<input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> End Stage Renal Disease
Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Family		Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Family		<input type="checkbox"/> Other Disability	<input type="checkbox"/> Other Disability
Name of Insurance Company:		Name of Insurance Company:		Medicare HIC Number:	Medicare HIC Number:
Telephone Number:		Telephone Number:		Part A Effective Date:	Part A Effective Date:
Address of Claims Center		Address of Claims Center		Part B Effective Date:	Part B Effective Date:
Does the above insurance cover <u>all</u> family members, including yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please list the names of all dependents not covered.		Does the above insurance cover <u>all</u> family members, including yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please list the names of all dependents not covered.			

34. Change Authorization

I hereby authorize the changes to my Capital Health Plan (CHP) contract. I understand and agree that the changes will not be effective until this application is accepted by CHP. I authorize any physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company or other organization, institution, or person that has records or knowledge of me or my eligible family members to give that information to CHP (or other affiliated carrier). This release specifically includes, but is not limited to, authorization to release any and all medical records and information associated with reference to certain conditions. I authorize CHP to exchange benefit information with any insurance company, organization, or individual to determine the applicability of the coordination of benefits provision for myself and my eligible family members for treatment, payment, and/or health care operations purposes. I represent that my statements on this application are true and compete and understand and agree that any misstatements may result in denial of benefits and/or termination of coverage.

Acceptance of any Coverage/Membership:

I have read and understand the Change Authorization above.

Signature of Certificate Holder/Covered Employee Date

Signature of Employer Representative Date

35. Dependent's alternate address information:

Name	Alternate Address

FRAUD NOTICE: I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.