

Group Change Form

Please read carefully and provide all applicable information.

Employee Last Name (Print)	First Name (Print)	Member ID No.
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Group Medical No.	Group Dental No.	Life Group No.
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Type of Change: Name Address Dependent Status Medical/Dental Office Life Insurance Declining Coverage

NAME CHANGE		ADDRESS CHANGE	
<input type="checkbox"/> Employee name only <input type="checkbox"/> Entire family		New Address	
New Name: _____		City	State ZIP Code
		New Phone No.	

DEPENDENT STATUS CHANGE		DECLINATION INFORMATION	
<input type="checkbox"/> Add Domestic Partner - Date of registration: ____/____/____		I understand that if I terminate or decline coverage at this time, if I choose to apply for enrollment at a later date, I may be excluded from coverage until the employer's next open enrollment, or 12 months from date of application, at which time I may reapply for coverage. In addition, once re-enrolled, I understand that my coverage may be subject to a six-month exclusion for pre-existing conditions. This exclusion also applies to any dependents on this declination. If you are declining coverage for yourself, your spouse, domestic partner or your dependents because of other health insurance coverage, you must tell us. You may enroll yourself or your dependents in this plan provided you request enrollment within 31 days after your coverage ends. You may also enroll following marriage (with your spouse), registration (with your domestic partner), childbirth or adoption (with your spouse and that child only) provided you request enrollment within 31 days after the marriage, registration, birth or adoption.	
<input type="checkbox"/> Add Spouse - Date of marriage: ____/____/____			
<input type="checkbox"/> Add Family Member - Effective date: ____/____/____ Reason: _____ Is family member currently being added on Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Both Name of Medicare dependent: _____			
<input type="checkbox"/> Remove Family Member(s) - Effective date: ____/____/____ Name(s): _____ Reason: _____			

MEDICAL/DENTAL OFFICE CHANGE	
<input type="checkbox"/> Office Change* * For medical office changes, please indicate below under the Anthem Blue Cross HMO (CaliforniaCare) IPA Primary Care Physician Code section.	Dental Office No.: _____

LIFE BENEFICIARY				
Primary Name (first to receive payment)	%	Relationship	Birthdate	Social Security No.

FAMILY ADDITIONS

Complete the information below for all family and/or spouse additions or medical office selections and/or changes. Check the disabled box only if the condition prohibits the member from working or performing daily activities. Please indicate if family member is covered by another health insurance plan by checking the Other Health coverage box. Complete the Prior Coverage section below, if applicable. For Anthem Blue Cross HMO and POS plans only, each person listed must choose a Medical Group or Independent Practice Association (IPA) within their enrollment area. IF YOU SELECT AN IPA, YOU MUST INDICATE A PRIMARY CARE PHYSICIAN FROM WITHIN THAT IPA. If you need assistance, contact Anthem Blue Cross at the number listed on your Membership ID Card or your health benefit officer.

To be eligible as a Domestic Partner, the Employee and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

Relation	Last Name	First	M.I.	Sex	Birthdate Mo/Day/Yr	Age	Social Security No.	If children are age 19 or over, you must check the appropriate boxes below	Totally Disabled	Coverage	Has other health coverage	Medical Group/ IPA Office No.	Anthem Blue Cross HMO IPA Primary Care Physician Code	Is this your current doctor
Self	Same as above	Same as above							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N
Child				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N
Child				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N
Child				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Y <input type="checkbox"/> N			<input type="checkbox"/> Y <input type="checkbox"/> N

PRIOR COVERAGE

If, immediately prior to becoming eligible for this plan, you or your eligible dependents were covered under any public or private health care coverage, please complete the section below to receive credit for that coverage. According to Federal Law, your employer or former carrier must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

Name	Date Began	Date Ended	Prior Carrier Name	Reason for Ending Coverage

Employee Signature X	Date
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FOR OFFICE USE ONLY
Effective Date:



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