HIGHMARK® Delaware

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:

❑ Enrollment Changes

❑ Cancel Entire Contract

❑ COBRA Continuant

Start Date ____________________

(Please attach a copy of COBRA Election Notice.)

DEPENDENT CHANGES:

Add dependent(s) due to HIPAA Life Event:

❑ Birth ❑ Marriage ❑ Adoption ❑ Other ____________________

Date of Above Event ____________________

(Please attach a copy of HIPAA Certification Form, if applicable.)

Cancel dependents due to:

❑ Divorce ❑ Death ❑ Other ____________________

Date of Above Event ____________________

OTHER CHANGES:

❑ New Name

❑ New Address

❑ Change to Medicare Eligible

❑ Change Coverage

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	

Product Selection(s)	
❑ Medical ❑ Vision ❑ Dental	

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
		❑ Yes ❑ No

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	/ /	

Product Selection(s)

❑ Medical ❑ Vision ❑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Spouse/DP an Established Patient?
		❑ Yes ❑ No

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
	❑ Male ❑ Female	/ /	

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Child an Established Patient?
		❑ Yes ❑ No

If Over Age 25, is Dependent Disabled?	Product Selection(s)
❑ Yes ❑ No	❑ 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.

DEPENDENT CHILD #2

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

Social Security Number *(If no SS#, write N/A)*	Gender ❑ Male ❑ Female	Date of Birth *(Month/Day/Year)* / /	Age

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Child an Established Patient? ❑ Yes ❑ No

If Over Age 25, is Dependent Disabled? ❑ Yes ❑ No	Product Selection(s) ❑ Medical ❑ Vision ❑ Dental

DEPENDENT CHILD #3

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

Social Security Number *(If no SS#, write N/A)*	Gender ❑ Male ❑ Female	Date of Birth *(Month/Day/Year)* / /	Age

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Child an Established Patient? ❑ Yes ❑ No

If Over Age 25, is Dependent Disabled? ❑ Yes ❑ No	Product Selection(s) ❑ 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.

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 Product as described in the agreement between Highmark Delaware 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 (877) 736-5708 or mail the forms to the following address:

Enrollment Services
P.O. Box 8868
Wilmington, DE 19899

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