



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
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REASON FOR COMPLETION: <input type="checkbox"/> Enrollment Changes <input type="checkbox"/> Cancel Entire Contract <input type="checkbox"/> COBRA Continuant Start Date _____ <i>(Please attach a copy of COBRA Election Notice.)</i>	DEPENDENT CHANGES: Add dependent(s) due to HIPAA Life Event: <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption <input type="checkbox"/> Other _____ Date of Above Event _____ <i>(Please attach a copy of HIPAA Certification Form, if applicable.)</i> Cancel dependents due to: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other _____ Date of Above Event _____	OTHER CHANGES: <input type="checkbox"/> New Name <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage Date of Above Event _____
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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
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Address	City	State	Zip	County
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Date of Birth (Month/Day/Year) / /	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Employment Status <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Disabled	Social Security Number (If no SS#, write N/A)
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Product Selection(s)
 Medical Product Name _____ Vision Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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COVERED DEPENDENT INFORMATION (If additional space is required, attach a separate sheet)

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner [†]
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Social Security Number (If no SS#, write N/A)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / /	Age
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*
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Social Security Number (If no SS#, write N/A)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / /	Age
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Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Child an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If Over Age 25, is Dependent Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Product Selection(s) <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental
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*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? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Over Age 25, is Dependent Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		Product Selection(s) <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental	

DEPENDENT CHILD #3

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Over Age 25, is Dependent Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		Product Selection(s) <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> 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 <input type="checkbox"/> Active <input type="checkbox"/> 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	
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> 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