Capital Health PLAN[SM]

An Independent Licensee of the Blue Cross and Blue Shield Association

MEMBER STATUS CHANGE REQUEST FORM

Complete only if **presently insured** by Capital Health Plan.

Changes must be made in accordance with your contract.

CHP USE ONLY:

Contract #: ____________

Group ID: ____________

Member ID:____________

THE BACK OF THIS FORM MUST BE COMPLETED

I. GENERAL INFORMATION

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

5. TYPE OF CHANGE:	***6. TYPE COVERAGE REQUESTED:***	***7. REASON FOR CHANGE:***	
☐ Name Change ☐ Address Change ☐ Add Dependent ☐ Cancel Dependent ☐ Cancel Coverage ☐ Change to Retiree* ☐ Other ____________________ ***Effective Date of Change:*** __________	☐ Employee ☐ Employee/Spouse* ☐ Employee/Child* ☐ Employee/Family * Only available when offered.	☐ Marriage** 🗐 ☐ Death** ☐ Terminate Employment** ☐ Divorce** 🗐 ☐ Birth** ☐ Adoption** 🗐 ☐ Retirement	☐ Over-age Dependent ☐ Moved from Service Area** ☐ Leave of Absence/Layoff** ☐ Other Insurance ☐ Open Enrollment ☐ Loss of Other Coverage** 🗐 ☐ Other ____________________

** ***Date of Event*** ________________________

🗐 ***Supporting documentation required.***

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. Relation-ship	11. Date of Birth	12. Disabled	14. Primary Care Physician (First Initial and Last Name)	15. Current Patient
Add Spouse	☐ Male ☐ Female					☐ Yes ☐ No		☐ Yes ☐ No
Add Dependent	☐ Male ☐ Female			☐ My Child ☐ Stepchild ☐ Other 🗐		☐ Yes ☐ No		☐ Yes ☐ No
Add Dependent	☐ Male ☐ Female			☐ My Child ☐ Stepchild ☐ Other 🗐		☐ Yes ☐ No		☐ Yes ☐ No
Add Dependent	☐ Male ☐ Female			☐ My Child ☐ Stepchild ☐ Other 🗐		☐ Yes ☐ No		☐ Yes ☐ No
Add Dependent	☐ Male ☐ Female			☐ My Child ☐ Stepchild ☐ Other 🗐		☐ Yes ☐ No		☐ Yes ☐ 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: ☐ Age ☐ Divorce ☐ Marriage ☐ Death ☐ Other – Please explain:

CHANGES

25. ☐ **Address Change**	26. New address:	27. Telephone Number:
28. ☐ **Name Change** 🗐	29. Change Name From: To:	
30. ☐ **Other**		

Please return this completed form by:
Mail: Capital Health Plan*Attn: Enrollment*PO Box 15349*Tallahassee FL 32317 **Fax:** 850-523-7369 **OR** **Email:** Enrollment@chp.org

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IV. OTHER CARRIER LIABILITY INFORMATION – *THIS SECTION MUST BE COMPLETED IF YOU ARE ADDING DEPENDENTS*

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) below. If more space is required, attach a separate sheet.

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

32. 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 Subscriber/Covered Employee Date Signature of Employer Representative Date

33. 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.