

HOW TO COMPLETE YOUR MEMBER CHANGE FORM

Complete the following fields on the Member Change Form.

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- 1) **Employer Name** - The employer's name.
 - 2) **Telephone Number** - The employer's telephone number.
 - 3) **Association Name** - The Association's name if your group participates in an association.
 - 4) **Group Number** - Unique 8 digit identification number assigned to the group.
 - 5) **Employee** - The employee's last name, first name and middle initial.
 - 6) **Member Identification Number** - The member's Social Security Number.
 - 7) **Effective Date** - The effective date of the change.
 - 8) **Please give a brief description of the changes to be made** - Utilize this field to describe any of the changes below if further clarification is required.
- Complete only the sections that apply to changes in member records.**
- 9) Complete the Street Address, City, State, Zip Code, Home Phone, Work Phone, Hire Date, Group No., Report Code, Change to Enrollment Status.
 - 10) **Employee/Contract Holder** - Complete the appropriate fields in this column to indicate changes that apply to the employee/contract holder.
 - 11) **Spouse/Domestic Partner** - Complete the appropriate fields in this column to indicate changes that apply to the spouse of the employee.
 - 12) **Dependent** - Complete the appropriate fields in these columns to indicate changes that apply to the dependent(s) of the employee.
 - 13) **Type of Change:**
 - Add** - Check this box if adding a new contract holder spouse or dependent to the existing group.
 - Termination** - Check this box if canceling a member. Indicate the reason for termination.
 - Change** - Check this box if changing the member's records.
 - 14) **Previous Identification Number** - The Social Security number of the covered individual prior to the change.
 - 15) **Current Identification Number** - The new Social Security number of the covered individual.
 - 16) **Previous Last Name** - The last name of the covered individual prior to the change.
 - 17) **Current Last Name** - The last name of the covered individual.
 - 18) **First Name Middle Initial** - The first name and middle initial of the covered individual.
 - 19) **Sex** - The gender of the covered individual.
 - 20) **Member Status** - The relationship of the spouse/domestic partner or dependent children to the employee. Check the appropriate box.
 - 21) **Birthdate** - The birthdate including Month/Day/Year of the covered individual.
 - 22) **Primary Care Physician Name** - Only Managed Care groups should complete this section.
 - 23) **Primary Care Physician Number** - Only Managed Care groups should complete this section.
 - 24) **Existing Patient?** - Only Managed Care groups should complete this section. Check "Yes" if the covered individual is already a patient of the Primary Care Physician. Check "No" if the covered individual is a new patient.
 - 25) **Marriage Date** - The member's marriage date.
 - 26) **Other Insurance/Medical Insurance** - Complete if you, your spouse/domestic partner or one of your eligible dependents has other health insurance coverage or is eligible for Medicare. Refer to your Medicare card to complete the Medicare Information section.
 - 27) **Signature and Date** - The employee and employer must both sign and date the form.



MEMBER CHANGE FORM

Membership Department
P.O. Box 890172
Camp Hill, PA 17089

In order to process this Change Form, the name and Member Identification Number of the Employee/Contract Holder must be completed in the space provided.

Employer Name		Employer Telephone Number ()		Association Name (if applicable)	
Group Number	Employee (Last)	(First)	(M.I.)	Member Identification Number	
Effective Date of Change	Please give a brief description of the changes to be made.				

COMPLETE ONLY THE SECTIONS THAT APPLY TO CHANGES IN MEMBER RECORDS.

Street Address			City		State	Zip Code	Home Phone ()		Work Phone ()	
Hire Date		Group No.	Report Code		Change Enrollment Status to:		☐ Single ☐ Insured & Spouse/Domestic Partner		☐ Parent/Child ☐ Parent/Children ☐ Family	
Type of Change	Employee/Contract Holder		Spouse/Domestic Partner		Dependent		Dependent		Dependent	
	☐ Add ☐ Change ☐ Terminate (indicate reason)		☐ Add ☐ Change ☐ Terminate (indicate reason)		☐ Add ☐ Change ☐ Terminate (indicate reason)		☐ Add ☐ Change ☐ Terminate (indicate reason)		☐ Add ☐ Change ☐ Terminate (indicate reason)	
	☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare		☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare		☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare		☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare		☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	
Previous Identification Number										
Current Identification Number										
Previous Last Name	Last		Last		Last		Last		Last	
Current Last Name	Last		Last		Last		Last		Last	
First Name Middle Initial	First M.I.		First M.I.		First M.I.		First M.I.		First M.I.	
Sex	☐ Male ☐ Female		☐ Male ☐ Female		☐ Male ☐ Female		☐ Male ☐ Female		☐ Male ☐ Female	
Member Status	(20) Employee		(01) ☐ Spouse (29) ☐ Domestic Partner		(02) ☐ Child (02) ☐ Disabled (07) ☐ Nephew (17) ☐ Stepchild (20) ☐ Act 4 (Adult Dependent)		(02) ☐ Student (05) ☐ Grandchild (07) ☐ Niece (20) ☐ Act 4 (Adult Dependent)		(02) ☐ Child (02) ☐ Disabled (07) ☐ Nephew (20) ☐ Act 4 (Adult Dependent)	
Birthdate	Month / Day / Year		Month / Day / Year		Month / Day / Year		Month / Day / Year		Month / Day / Year	
Primary Care Physician Name										
Primary Care Physician Number										
Existing Patient?	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
Marriage Date	Month / Day / Year		Month / Day / Year		Month / Day / Year		Month / Day / Year		Month / Day / Year	

Please check one if applicable (If additional space is required, attach a separate sheet). If you ☐, your spouse/domestic partner ☐, or dependent(s) ☐, are enrolled in another Program or Medicare, please give the following information:

Name of Insurance Carrier: _____
Group No: _____ Effective Date: _____
Name of Policy Holder: _____
Policy Number: _____
Relationship to Highmark Policy Holder: _____
Policy Holder Date of Birth: _____
Policy Holder Employment Status: ☐ Active ☐ Retired (Date) _____

MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits:

Name of Member	Health Insurance Claim Number	Part A Effective Date (Mo-Day-Yr)	Part B Effective Date (Mo-Day-Yr)	Part D Effective Date (Mo-Day-Yr)
Last First		/ /	/ /	/ /
		/ /	/ /	/ /

Why are you eligible for Medicare? ☐ Age ☐ Disability ☐ End Stage Renal Disease

Do you have a Medicare Supplement or other coverage that complements Medicare? ☐ Yes ☐ No

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. I understand that this form enrolls those eligible persons listed above in the Medical Plan as described in the agreement between the plan 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. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

Authorized Employer Signature

Date

Employee Signature

Date