Member Change Form

***Instructions*:** Please complete in ink and return to your employer. Use extra sheets of paper if necessary. Anthem's Primary Care Physician (PCP) listings can be obtained through www.anthem.com.
IF ADDING AN ELIGIBLE DEPENDENT PLEASE COMPLETE ENROLLMENT APPLICATION.

MCF

GROUP INFORMATION – This section should be completed by Group Administrator (if applicable)

❑ **HealthKeepers, Inc. (HMO)** ❑ **Priority Health Care, Inc. (HMO)**
❑ **Peninsula Health Care, Inc. (HMO)** ❑ **Anthem Blue Cross and Blue Shield (Par/PPO)**

Group Name	Group Number	Effective date of change (subject to plan guidelines) Mo Day Year

MEMBER INFORMATION (please print or type)

Member identification number (Please provide information as shown on your ID card):

Last name | First name | M.I.

❑ ***Personal Data Change***
(Please check the appropriate boxes and complete only those items requesting to be changed as of the effective date noted above. For social security number, attach appropriate documentation.)

❑ **Name Change** (employee only) ❑ **Address Change**
❑ **Name Correction** (employee & dependent) ❑ **Phone Number Change**
❑ **Social Security Number Correction**

New name - Last name | First Name | M.I.

New address - Street | Apt. #

City | State | Zip

New daytime phone (with area code) ( ) | New evening phone (with area code) ( ) |

Correction of social security number |

❑ ***Change in Type of Membership*** ❑ **Remove all dependent(s)** ❑ **Remove spouse** ❑ **Remove child** (please provide child's last and first name): _____

❑ ***Primary Care Physician (PCP) Change***

Member's first name	Current physician	New physician	Current patient?
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

❑ ***Cancellation of Coverage*** ❑ Left organization ❑ Divorced ❑ Moved out of service area ❑ Deceased

Authorization

I authorize the changes, as shown above, to be made by the requested effective date. I authorize my employer to make changes in payroll deductions if required by the health coverage changes I have made. I understand that these changes are effective only after they are accepted by my employer and received by the health care company.

Member signature | Date | Home Telephone

Employer or Group Administrator signature (if applicable) | Date | Telephone

For use by current members only. This is not an application. A new employee must complete an enrollment application.

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