MEMBER STATUS CHANGE REQUEST FORM

Use only for presently insured Capital Health Plan Members
Note: Changes must be made in accordance with your contract

Please complete and return this form with any change(s) by: **Mail:** Capital Health Plan; Attn: Enrollment; PO Box 15349; Tallahassee FL 32317 **Fax:** 850.523.7369 **OR Email:** Enrollment@chp.org

1. Name of Group Employer:		2. Group Administrator Email:
3. Printed Name of Authorized Group Administrator:	4. Phone #:	5. Group #:

Subscriber Information

6. Subscriber's Name (Last, First, MI):	7. CHP ID #:
8. Check type of change: ☐Add Dependent(s) ☐Address Change ☐Cancel All Coverage ☐Cancel Dependent(s) ☐Change to Retiree ☐Name Change ☐Other___________________________________	Effective Date of Change:
9. Check reason for change: (∗ *Attach the Supporting documentation)* ☐Adoption∗ ☐Birth ☐Death ☐Divorce∗ ☐Marriage∗ ☐Leave of Absence/Layoff ☐Loss of Other Coverage∗ ☐Moved from Service Area ☐Open Enrollment ☐Other Insurance ☐Over-age Dependent ☐Retirement ☐Termination of Employment ☐Name Change∗ ☐Other___________________________________	Actual Date of Event:

Additions/Deletions of Eligible Family Members (Attach a Separate Sheet, if necessary)

	10. Name First Name, Middle Initial & Last Name (if not the same)	11. Relation-ship	12. Sex/Date of Birth	13. SSN	14. Disabled	15. Primary Care Physician	16. Current Patient
☐ Add ☐ Delete			☐ M ☐ F		☐ Yes ☐ No		☐ Yes ☐ No
☐ Add ☐ Delete			☐ M ☐ F		☐ Yes ☐ No		☐ Yes ☐ No
☐ Add ☐ Delete			☐ M ☐ F		☐ Yes ☐ No		☐ Yes ☐ No
☐ Add ☐ Delete			☐ M ☐ F		☐ Yes ☐ No		☐ Yes ☐ No
☐ Add ☐ Delete			☐ M ☐ F		☐ Yes ☐ No		☐ Yes ☐ No

Changes: Name and or Address

New Address	17. Member Permanent Residence Street Address: 18. Mailing Address:	19. Telephone Number:
Name Change *	20. From:	To:
Dependent Alternate Address	21. Dependent Name: 22. Address:	23. Dependent Name: 24. Address:
Dependent Alternate Address	25. Dependent Name: 26. Address:	27. Dependent Name: 28. Address:

29. Do you, your spouse, or dependents have other health care coverage? ☐ Yes ☐ No (If yes, complete the appropriate section(s) on the reverse side of this form)

Acceptance of any Coverage/Membership:

I have read and understand the Change Authorization on the reverse side of this form and the Fraud Warning below:

____ Signature of Subscriber/Covered Employee Date

____ Signature of Authorized Group Administrator Date

Fraud Warning:

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.

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If more space is needed, attach a separate sheet with additional information.

Other Health Plan Insurance	Medicare	
Insured Member's Name: Date of Birth:	Beneficiary Name:	Beneficiary Name:
Employment Status: Name of Employer: ☐Active ______________________ ☐ Retired Type of coverage: ☐ Single ☐ Family	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 #:	Medicare MBI Number:	Medicare MBI Number:
Name of Insurance Company: Phone:	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 dependents not covered on a separate sheet.	Part B Effective Date:	Part B Effective Date:

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, compete, and I understand, and agree that any misstatements may result in denial of benefits and/or termination of coverage.