HIGHMARK® HEALTH INSURANCE COMPANY

MEMBER CHANGE FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY IN BLUE OR BLACK INK.
DO NOT USE PENCIL OR HIGHLIGHTER.

For Changes: Highmark
P.O. Box 890172
Camp Hill, PA 17089-0172

EMPLOYEE APPLICATION INFORMATION

Effective Date	Employer Name	Group Number	Payroll Location

REASON FOR COMPLETION:

❑ Changes ❑ Act4 ❑ Cancel

❑ COBRA

Start Date _____

End Date _____

DEPENDENT CHANGES:

Add dependents due to:

❑ Birth ❑ Marriage ❑ Adoption

Date of Above Event _____

Drop dependents due to:

❑ Divorce ❑ Death ❑ Other _____

Date of Above Event _____

OTHER CHANGES:

❑ New Name
❑ New Address
❑ Change to Medicare Eligible
❑ Change Coverage
❑ Other _____

Date of Above Event _____

CANCEL/COBRA REASON:

❑ Deceased
❑ Left Employment
❑ Involuntary Lay-Off
❑ Other Coverage
❑ Other _____

Date of Above Event _____

Employee's Last Name | First Name | MI | Social Security Number

Street Address | City | State | Zip | County

Birth Date Month / Day / Year	Gender	Marital Status	Employment Status	Date of Full-Time Hire Mo / Da / Yr	Hours Worked Per Week	E-mail Address (optional)
	❑ M ❑ F	❑ Single ❑ Married ❑ Widowed ❑ Divorced	❑ Active ❑ COBRA ❑ Disabled			

COVERED DEPENDENT INFORMATION

Covered Dependents Relationship	First Name	Last Name	Social Security #	Birth date Mo/Da/Yr	Gender M/F	Dependent Status If Over Age 26
❑ Spouse ❑ Dom. Part.* ___						
❑ Child ❑ Other* ___						❑ Disabled
❑ Child ❑ Other* ___						❑ Disabled
❑ Child ❑ Other* ___						❑ Disabled

*If "domestic partner" or "other" applies, complete using one of the following codes: (02) Adopted Child, (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter and (29) Domestic Partner. Legal Documentation (Court Decree, Guardianship Papers, etc.) must be attached to this Application if relationship is "Other".

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 Members Last	First	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)
			/ /	/ /	/ /
			/ /	/ /	/ /

Why are you eligible for Medicare?: ❑ Age ❑ Disability ❑ End Stage Renal Disease
Do you have a Medicare Supplement or other coverage that compliments Medicare? ❑ Yes ❑ No

IMPORTANT: AUTHORIZED SIGNATURES (REQUIRED)

I understand that this form enrolls those eligible persons listed above in the Products 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. 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 Signature: _____ **Date:** _____

Authorized Employer Signature: _____ **Date:** _____