

# 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)**

<input type="checkbox"/> HealthKeepers, Inc. (HMO)	<input type="checkbox"/> Priority Health Care, Inc. (HMO)	Effective date of change (subject to plan guidelines)
<input type="checkbox"/> Peninsula Health Care, Inc. (HMO)	<input type="checkbox"/> Anthem Blue Cross and Blue Shield (Par/PPO)	
Group Name	Group Number	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.
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**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 child (please provide child's last and first name): \_\_\_\_\_  
 Remove spouse

**Primary Care Physician (PCP) Change**

Member's first name	Current physician	New physician	Current patient?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> 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.*