Change Form

Employee Information

Name (First/M.I./Last): _____ **Social Security Number:** _____

Effective Date of Change: _____

Reason for Change (Select): Other **If other, please specify:** _____

Change my Group to (Please check box and insert group number):

- ☐ **Medical Plan: Group Number** _____
- ☐ **Dental Plan: Group Number** _____
- ☐ **Vision Plan: Group Number** _____

Change my Tier to (Please check box and select type of coverage):

- ☐ **Medical Plan:** N/A
- ☐ **Dental Plan:** N/A
- ☐ **Vision Plan:** N/A

Complete only the sections that apply to changes in member records.

Address Change

Street Address:	City:	State:	Zip Code:	Home Phone:

List Member Changes

Please select "A" for Add or "R" for Remove	Name (First Name/Middle Initial/Last Name)	Social Security Number	Date of Birth	Gender (M/F)	Relationship (Self/Spouse/Child, etc.)	Please Note if Member is: Dependent over 19**/ Disabled	Do you have other insurance? Yes* or No
N/A				F	None	N/A	No
N/A				F	None	N/A	No
N/A				F	None	N/A	No
N/A				F	None	N/A	No
N/A				F	None	N/A	No

*If you noted "Yes" for other insurance coverage, please complete the additional applicable sections on the reverse side of this form to provide the required information.

By my signature on this form, I certify that all dependents listed above are eligible for health care coverage under the Health Plan, and that the information is correct and current as of the date signed. I further understand that if I misrepresent my dependent eligibility for health coverage, I will be responsible for any premium and/or claim repayments for the period of time during which the misrepresentation occurred and may be subject to disciplinary measures, up to and including termination.

Form must be printed and signed.

Employee Signature: _____ **Date:** _____

**An Adult Dependent Child Affidavit must be completed for each dependent 19 years and over. Proper documentation (i.e. birth certificate, etc.) must be presented to validate dependent's relationship to the employee.

Enrollment Form – Other Insurance Coverage

Other Insurance Coverage – Please complete if you indicated "Yes" on the Enrollment Form.

Please complete the following section:

Name of Insurance Carrier:	
Group Number:	
Effective Date:	
Name of Policy Holder:	
Policy Number:	
Relationship to Highmark Policy Holder:	
Policy Holder Date of Birth:	
Policy Holder Employment Status (Select):	Retired

Please list any family member that is eligible for Medicare Benefits:

Name of Member (First Name/Last Name):	
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 (Select):	N/A
Do you have a Medicare Supplement or other coverage that complements Medicare (Select):	No