# Group Change Form

Please read carefully and provide all applicable information.

| Employee Last Name (Print) | First Name (Print) | Member ID No. |
|---|---|---|
| | | |

Type of Change: ☐ Name ☐ Address ☐ Dependent Status ☐ Medical/Dental Office ☐ Life Insurance

## NAME CHANGE

☐ Employee name only ☐ Entire family

New Name: _____

## ADDRESS CHANGE

New Address

City | State | ZIP Code

New Phone No.

## MEDICAL/DENTAL OFFICE CHANGE

☐ **Office Change***

* For medical office changes, please indicate below under the Anthem Blue Cross HMO (CaliforniaCare) IPA Primary Care Physician Code section.

Dental Office No.:

## LIFE BENEFICIARY

| Primary Name (first to receive payment) | % | Relationship | Birthdate | Social Security No. |
|---|---|---|---|---|
| | | | | |
| | | | | |

## FAMILY ADDITIONS

Complete the information below for all family and/or spouse additions or medical office selections and/or changes. Check the disabled box only if the condition prohibits the m
Complete the Prior Coverage section below, if applicable. For Anthem Blue Cross HMO and POS plans only, each person listed must choose a Medical Group or Independent Prac
contact Anthem Blue Cross at the number listed on your Membership ID Card or your health benefit officer.

To be eligible as a Domestic Partner, the Employee and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State
domestic partnerships.

| Relation | Last Name | First | M.I. | Sex | Birthdate Mo/Day/Yr | Age | Social Security No. |
|---|---|---|---|---|---|---|---|
| Self | Same as above | Same as above | | | | | |
| ☐ Spouse ☐ Domestic Partner | | | | ☐ M ☐ F | | | |
| Child | | | | ☐ M ☐ F | | | |
| Child | | | | ☐ M ☐ F | | | |
| Child | | | | ☐ M ☐ F | | | |
| Child | | | | ☐ M ☐ F | | | |

## PRIOR COVERAGE

If, immediately prior to becoming eligible for this plan, you or your eligible dependents were covered under any public or private health care coverage, please complete the sec
According to Federal Law, your employer or former carrier must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a co

| Name | Date Began | Date Ended | Prior Carrier Name | Reason for Ending Coverage |
|---|---|---|---|---|
| | | | | |
| | | | | |

| Employee Signature | Date |
|---|---|
| X | |

**FOR OFFICE USE ONLY**
Effective Date:

**WHITE** - Anthem Blue Cross Membership **YELLOW** - Employer **PINK** - Employee

| Group Medical No. | Group Dental No. | Life Group No. |
|---|---|---|
| | | |

☐ Declining Coverage

## DEPENDENT STATUS CHANGE

☐ **Add Domestic Partner** - Date of registration: ____/____/____

☐ **Add Spouse** - Date of marriage: ____/____/____

☐ **Add Family Member** - Effective date: ____/____/____

Reason: _____

Is family member currently being added on Medicare? ☐ Yes ☐ No

If yes: ☐ Part A ☐ Part B ☐ Both

Name of Medicare dependent: _____

☐ **Remove Family Member(s)** - Effective date: ____/____/____

Name(s): _____ Reason: _____

## DECLINATION INFORMATION

I understand that if I terminate or decline coverage at this time, if I choose to apply for enrollment at a later date, I may be excluded from coverage until the employer's next open enrollment, or 12 months from date of application, at which time I may reapply for coverage.

In addition, once re-enrolled, I understand that my coverage may be subject to a six-month exclusion for pre-existing conditions. This exclusion also applies to any dependents on this declination. If you are declining coverage for yourself, your spouse, domestic partner or your dependents because of other health insurance coverage, you must tell us. You may enroll yourself or your dependents in this plan provided you request enrollment within 31 days after your coverage ends. You may also enroll following marriage (with your spouse), registration (with your domestic partner), childbirth or adoption (with your spouse and that child only) provided you request enrollment within 31 days after the marriage, registration, birth or adoption.

| **Secondary Name** (second to receive payment) | % | **Relationship** | **Birthdate** | **Social Security No.** |
|---|---|---|---|---|
| | | | | |
| | | | | |

ember from working or performing daily activities. Please indicate if family member is covered by another health insurance plan by checking the Other Health coverage box.
tice Association (IPA) within their enrollment area. IF YOU SELECT AN IPA, YOU MUST INDICATE A PRIMARY CARE PHYSICIAN FROM WITHIN THAT IPA. If you need assistance,

pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of

| If children are age 19 or over, you must check the appropriate boxes below | | Totally Disabled | Coverage | Has other health coverage | Medical Group/ IPA Office No. | Anthem Blue Cross HMO IPA Primary Care Physician Code | Is this your current doctor |
|---|---|---|---|---|---|---|---|
| | | ☐Y ☐N | ☐Medical ☐Dental ☐Vision | ☐Y ☐N | | | ☐Y ☐N |
| **Qualifies as IRS Dependent** | **Full-time Student** | ☐Y ☐N | ☐Medical ☐Dental ☐Vision | ☐Y ☐N | | | ☐Y ☐N |
| ☐Y ☐N | ☐Y ☐N | ☐Y ☐N | ☐Medical ☐Dental ☐Vision | ☐Y ☐N | | | ☐Y ☐N |
| ☐Y ☐N | ☐Y ☐N | ☐Y ☐N | ☐Medical ☐Dental ☐Vision | ☐Y ☐N | | | ☐Y ☐N |
| ☐Y ☐N | ☐Y ☐N | ☐Y ☐N | ☐Medical ☐Dental ☐Vision | ☐Y ☐N | | | ☐Y ☐N |
| ☐Y ☐N | ☐Y ☐N | ☐Y ☐N | ☐Medical ☐Dental ☐Vision | ☐Y ☐N | | | ☐Y ☐N |

tion below to receive credit for that coverage.
py of this certificate.

| Name | Date Began | Date Ended | Prior Carrier Name | Reason for Ending Coverage |
|---|---|---|---|---|
| | | | | |
| | | | | |

Anthem Blue Cross