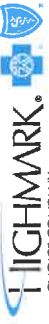




MEMBER CHANGE FORM

Membership Department • P.O. Box 535193 • Pittsburgh, PA 15253-5193



IN ORDER TO PROCESS THIS CHANGE FORM, THE NAME AND MEMBER IDENTIFICATION NUMBER OF THE EMPLOYEE/CONTRACT HOLDER MUST BE COMPLETED IN THE SPACE PROVIDED.

Employee Name		Employer Telephone Number (include area code)		Association Name (if applicable)		Member Identification Number	
Group Number		Employee (Last)		(M.I.)			
Effective Date of Change		Please give a brief description of the changes to be made.					
Street Address		City		State		Zip Code	
Hire Date		Group No.		Report Code		Change Enrollment Status to:	
		EMPLOYEE/CONTRACT HOLDER		SPOUSE/DOMESTIC PARTNER		DEPENDENT	
		☐ Add ☐ Change ☐ Terminate (indicate reason)		☐ Add ☐ Change ☐ Terminate (indicate reason)		☐ Add ☐ Change ☐ Terminate (indicate reason)	
Type of Change		☐ Deceased ☐ Married ☐ Divorced ☐ Medicare		☐ Deceased ☐ Married ☐ Divorced ☐ Medicare		☐ Deceased ☐ Married ☐ Divorced ☐ Medicare	
Previous Identification Number							
Current Identification Number							
Previous Last Name		Last		Last		Last	
Current Last Name		Last		Last		Last	
First Name Middle Initial		First		M.I.		First	
Sex		☐ Male ☐ Female		☐ Male ☐ Female		☐ Male ☐ Female	
Member Status		(20) Employee		(01) Spouse (29) Domestic Partner		(02) Child (05) Grandchild (07) Nephew (17) Stepchild (20) Act 4 (Adult Dependent)	
Birthdate		Month/ Day/Year		Month/ Day/Year		Month/Day/Year	
Primary Care Physician/ Physician of Record Name							
Primary Care Physician/ Physician of Record No.							
Existing Patient?		☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
Marriage Date		Month/Day/Year		Month/Day/Year		Month/Day/Year	

Please check one if applicable (If additional space is required, attach a separate sheet). If you ☐ are enrolled in another Program or Medicare, please give the following information:

Name of Insurance Carrier:	Name of Member Last/First	Health Insurance Date (Mo-Day-Yr)	Part A Effective Date (Mo-Day-Yr)	Part D Effective Date (Mo-Day-Yr)
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) _____	_____	_____	_____	_____

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. I understand that this form enrolls those eligible persons listed above in the Medical Plan 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. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

Authorized Employer Signature	Employee Signature	Date
	Highmark Blue Cross Blue Shield and Highmark Choice Company are independent licensees of the Blue Cross and Blue Shield Association	
		ENR-010 (R1-18)