Change Form

PriorityHealth

Priority Health • PO Box 205 • Grand Rapids, MI 49501-0205

(Member changes must be received by Priority Health within 31 days of the event.) Fax to 616 942-5242

SECTION 1 - EMPLOYEE INFORMATION

Employee's Last Name	First Name	Middle Initial	Social Security Number — —

SECTION 2 - CHANGES (Please complete only those changes which apply.)

☐ **ADDRESS/PHONE CHANGE**

Street Address	City	
State	Zip Code	Home Phone ( ) -	Work Phone ( ) -

☐ **NAME CHANGE**

New Last Name	Former Last Name

☐ **DEPENDENT CHANGE** **(If you have more than 4 dependent changes please complete an additional change form).** Date Change Occurred / / Reason for Change Add ☐ Delete ☐

1

Last Name	First Name	Middle Initial	Social Security Number — —

Birth Date / /	Sex Male ☐ Female ☐	Relation to Employee	Primary Care Provider **(REQUIRED for HMO & POS)**

Has this dependent ever seen this provider? Yes ☐ No ☐	PCP Address/ID Code

2

Last Name	First Name	Middle Initial	Social Security Number — —

Birth Date / /	Sex Male ☐ Female ☐	Relation to Employee	Primary Care Provider **(REQUIRED for HMO & POS)**

Has this dependent ever seen this provider? Yes ☐ No ☐	PCP Address/ID Code

3

Last Name	First Name	Middle Initial	Social Security Number — —

Birth Date / /	Sex Male ☐ Female ☐	Relation to Employee	Primary Care Provider **(REQUIRED for HMO & POS)**

Has this dependent ever seen this provider? Yes ☐ No ☐	PCP Address/ID Code

4

Last Name	First Name	Middle Initial	Social Security Number — —

Birth Date / /	Sex Male ☐ Female ☐	Relation to Employee	Primary Care Provider **(REQUIRED for HMO & POS)**

Has this dependent ever seen this provider? Yes ☐ No ☐	PCP Address/ID Code

SECTION 3 - AUTHORIZATION

I authorize Priority Health to make the changes indicated above for me and my dependents. I understand that Priority Health may request pertinent sworn statements if needed and that I must sign and date this form before it will be processed.

Priority Health requires proper handling of personal health information for our members. Details of our confidentiality policies and procedures are available upon request.

X _____

Employee Signature Date

Employer Name	Group Number	Sub Group Number	Class

Employer/Representative Signature Date / /

Plan Change ☐ (If checked, please also check one of the following) HMO ☐ POS ☐ PPO ☐ HBC ☐ HRA ☐ HSA ☐

Plan Option (if applicable) High ☐ Mid ☐ Low ☐

REASONS FOR ADDITIONS

Marriage ☐ Birth ☐ Adoption ☐ Divorce ☐ Death ☐ Lost Eligibility ☐ Loss of other coverage (Proof Required) ☐ Other ☐ _____ Effective Date / /

REASONS FOR DELETIONS

Marriage of Dependent ☐ Divorce ☐ Death ☐ Lost Eligibility ☐ Other ☐ _____ Date Coverage Ended / /

REASON FOR TERMINATION OF ENTIRE CONTRACT — Date Occurred / / — Date Coverage Ended / /

Terminated Employment ☐ Lay Off ☐ Leave of Absence ☐ Changed Health Plans ☐ Moved out of area ☐

Death ☐ COBRA Terminated ☐ Dissatisfied ☐ Other ☐ _____

For Priority Health Use Only	Date Received / /	Processor	Code	Date Processed

In accordance with the Genetic Information Nondiscrimination Act (GINA) of 2008, Priority Health requests that you not include any genetic information on this form. Genetic information includes any genetic testing results of either yourself or a family member, your family health history or any requests for or receipt of genetic services.