HEALTH TRADITION

# Member Change Form

Send to: Health Tradition Health Plan
PO Box 21171
Eagan, MN 55121

Employer Group Name:_____ Effective Date of Change:_____

**Employee Information**

Name:_____
Last First M.I.

Address:_____

City/State/ZIP Code:_____

Employee Social Security No. or member ID No. (required):_____

❑ New telephone No.: Home (  )_____Work (  ) _____

❑ Check if name change Previous Name: _____

❑ Check if new address Previous Address:_____

_____

## Dependent Changes

When adding a dependent, you must enter Social Security Number. Adult children are eligible for coverage up to the end of the month in which they turn 26.

| CHECK ONE | | NAME | | BIRTH DATE | | | SEX | Relationship to Applicant | CHECK REASON* | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ADD | REMOVE | LAST FIRST | M.I. | MO. | DAY | YR. | F M | | Date of Marriage | Birth of Child | Date of Divorce | Return from Active Duty | Loss of Coverage |
| ☐ | ☐ | | | | | | | | | | | | |
| | | Social Security No. | | | | | | | | | | | |
| ☐ | ☐ | | | | | | | | | | | | |
| | | Social Security No. | | | | | | | | | | | |
| ☐ | ☐ | | | | | | | | | | | | |
| | | Social Security No. | | | | | | | | | | | |

***If adding a dependent due to Loss of Coverage, please include proof of loss of other group coverage (example: involuntary loss of coverage letter on employer letterhead or from prior group health insurance company).***

**Other Health Insurance**

On the date this change will take effect, will you or any family member(s) be covered by any other group medical insurance (not replacing this plan), including Medicare? ☐ Yes ☐ No

*If yes, please complete this information:*

Name of person with other insurance/plan_____ Type of coverage: ☐ Single ☐ Family

Please list names of covered family members_____

Name of Insurance Co._____ Phone No._____

Address _____ City _____ State _____ ZIP_____

Group No. _____ Certificate No. _____

Policy: Effective date _____ Termination date_____ Will you be terminating coverage? ☐ Yes ☐ No

Is this Is group policy/plan offered through an employer? ☐ Yes ☐ No If no, what is it offered through?_____

**Coverage Changes**

☐ **Change of contract status (single, family, employee + spouse, employee + children, retirement, etc.)**
From _____ To _____

☐ Change from eligible employee to state/federal continuation COBRA.
*(Please attach copy of signed member continuation form.)*

☐ Change from eligible dependent to state/federal continuation COBRA.
*(Please attach copy of signed member continuation form.)*

☐ Change of plan option (at renewal date only)_____

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**Termination**

To cancel coverage, check here:_____ Last day worked:_____

Reason for termination: ☐ Left employment ☐ Moved out-of-area ☐ Cancellation ☐ Deceased
☐ Reduction in hours ☐ Other ☐ Non-payment of COBRA premium

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I HEREBY apply for amendment of my enrollment application. I attest that, to the best of my knowledge, the information submitted on this form is correct. If authorized representative is signing, attach authorized representative documentation.

It is mutually agreed as follows: That these changes shall not become effective unless and until accepted by Health Tradition Health Plan. That this Member Change form will become a part of my original application and, if accepted, will be subject to terms in effect with my benefit plan.

_____ _____
Print Name Date Signed

_____ _____ _____
Authorized Signature Required Relationship to Employee Employer Group Name
*(Employee or Authorized Representative)*
*(If termination-Employer Representative)*