



HRA

MEMBER CHANGE FORM

Membership Department - P.O. Box 535193 - Pittsburgh, PA 15255-5193



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: WASHINGTON COUNTY
Group Number: 15518-
Effective Date of Change: -1-25
Association Name: WASHINGTON COUNTY
Member Identification Number: SSN

COMPLETE ONLY THE SECTIONS THAT APPLY TO CHANGES IN MEMBER RECORDS.

Table with columns for EMPLOYEE/CONTRACT HOLDER, SPOUSE/DOMESTIC PARTNER, and DEPENDENT. Includes fields for Type of Change, Previous/Current Identification Numbers, and Name/Address details.

MEDICARE INFORMATION section. Includes fields for Name of Insurance Carrier, Group No., Name of Policy Holder, Policy Number, and Effective 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.

Authorized Employer Signature: _____ Date: _____
Employee Signature: _____ Date: _____