HIGHMARK. Blue Cross Blue Shield

An Independent Licensee of the Blue Cross and Blue Shield Association

MEMBER CHANGE FORM

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

KEYSTONE HEALTH PLAN WEST
A HIGHMARK COMPANY

An Independent Licensee of the Blue Cross and Blue Shield Association

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.

Employer Name: WASHINGTON COUNTY		Employer Telephone Number ( )	Association Name (if applicable)	
Group Number	Employee (Last)	(First)	(M.I.)	Member Identification SSN:
Effective Date of Change	Please give a brief description of the changes to be made.			

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

Street Address	City	State	Zip Code	Home Phone ( )	Work Phone ( )
Hire Date	Group No.	Report Code	Change Enrollment Status to:	☐ Single ☐ Insured & Spouse/Domestic Partner ☐ Parent/Child	☐ Parent/Children ☐ Family

	Employee/Contract Holder	Spouse/Domestic Partner	Dependent	Dependent	Dependent
Type of Change	☐ Add ☐ Change ☐ Terminate (indicate reason) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare	☐ Add ☐ Change ☐ Terminate (indicate reason) ☐ Deceased ☐ Married ☐ Divorced ☐ Request Cancel ☐ Medicare
Previous Identification Number					
Current Identification Number					
Previous Last Name	Last	Last	Last	Last	Last
Current Last Name	Last	Last	Last	Last	Last
First Name Middle Initial	First M.I.	First M.I.	First M.I.	First M.I.	First M.I.
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Member Status	(20) Employee	(01) ☐ Spouse (29) ☐ Domestic Partner	(02) ☐ Child (02) ☐ Disabled (07) ☐ Nephew (17) ☐ Stepchild (02) ☐ Student (05) ☐ Grandchild (07) ☐ Niece (20) ☐ Act 4 (Adult Dependent)	(02) ☐ Child (02) ☐ Disabled (07) ☐ Nephew (17) ☐ Stepchild (02) ☐ Student (05) ☐ Grandchild (07) ☐ Niece (20) ☐ Act 4 (Adult Dependent)	(02) ☐ Child (02) ☐ Disabled (07) ☐ Nephew (17) ☐ Stepchild (02) ☐ Student (05) ☐ Grandchild (07) ☐ Niece (20) ☐ Act 4 (Adult Dependent)
Birthdate	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year
Primary Care Physician Name					
Primary Care Physician Number					
Existing Patient?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Marriage Date	Month / Day / Year	Month / Day / Year	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 ☐, your spouse/domestic partner ☐, or dependent(s) ☐, are enrolled in another Program or Medicare, please give the following information:

Name of Insurance Carrier: ____________

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) ____________

MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits:

Name of Member Last	First	Health Insurance Claim Number	Part A Effective Date (Mo-Day-Yr)	Part B Effective Date (Mo-Day-Yr)	Part D Effective Date (Mo-Day-Yr)
			/ /	/ /	/ /
			/ /	/ /	/ /

Why are you eligible for Medicare? ☐ Age ☐ Disability ☐ End Stage Renal Disease

Do you have a Medicare Supplement or other coverage that complements Medicare? ☐ Yes ☐ No

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 ____________ Date ____________

Employee Signature ____________ Date ____________

HBCBS COPY

ENR-010 (R12-09)