



MEMBER CHANGE FORM
COMPLETE THIS APPLICATION IN ITS ENTIRETY
IN **BLUE** OR **BLACK** INK.
DO NOT USE PENCIL OR HIGHLIGHTER.

EMPLOYEE/CONTRACT HOLDER INFORMATION

Effective Date	Employer/Group Name	Group Number	Payroll Location
REASON FOR COMPLETION: ☐ Enrollment Changes ☐ Cancel Entire Contract ☐ COBRA Continuant Start Date _____ (Please attach a copy of COBRA Election Notice.)	DEPENDENT CHANGES: Add dependent(s) due to HIPAA Life Event: ☐ Birth ☐ Marriage ☐ Adoption ☐ Other _____ Date of Above Event _____ (Please attach a copy of HIPAA Certification Form.) Cancel dependents due to: ☐ Divorce ☐ Death ☐ Other _____ Date of Above Event _____	OTHER CHANGES: ☐ New Name ☐ New Address ☐ Change to Medicare Eligible ☐ Change Coverage Date of Above Event _____	
CANCEL Reason for Contract Holder: ☐ Deceased ☐ Left Employment ☐ Involuntary Lay-Off ☐ Other Coverage ☐ Other _____ Date of Above Event _____			
Additional Comments:			

First Name	MI	Last Name	Home/Cell Phone		
Address		City	State	Zip	County
Date of Birth (Month/Day/Year) / /	Age	Gender ☐ Male ☐ Female	Employment Status ☐ Active ☐ COBRA ☐ Disabled	Social Security Number (If no SS#, write N/A)	
Product Selection(s) ☐ Medical Product Name _____ ☐ Vision ☐ Dental					
Full Name of Physician of Record (POR) Group Practice			POR Number from Provider Directory	Are you an Established Patient? ☐ Yes ☐ No	

COVERED DEPENDENT INFORMATION (If additional space is required, attach a separate sheet)

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You? ☐ Spouse ☐ Domestic Partner [†]		
Social Security Number (If no SS#, write N/A)		Gender ☐ Male ☐ Female	Date of Birth (Month/Day/Year) / /	Age	
Product Selection(s) ☐ Medical ☐ Vision ☐ Dental					
Full Name of Physician of Record (POR) Group Practice			POR Number from Provider Directory	Is Spouse/DP an Established Patient? ☐ Yes ☐ No	

Note: If spouse's last name differs from the contract holder above, please attach a copy of your marriage certificate.

[†]If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and financial verification documents to this application.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ☐ Child ☐ Step-child ☐ Adopted* ☐ Other*		
Social Security Number (If no SS#, write N/A)		Gender ☐ Male ☐ Female	Date of Birth (Month/Day/Year) / /	Age	
Full Name of Physician of Record (POR) Group Practice			POR Number from Provider Directory	Is Child an Established Patient? ☐ Yes ☐ No	
If Over Age 25, is Dependent Disabled? ☐ Yes ☐ No		Product Selection(s) ☐ Medical ☐ Vision ☐ Dental			

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custody/legal papers to support dependent eligibility.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ☐ Child ☐ Step-child ☐ Adopted* ☐ Other*	
Social Security Number (If no SS#, write N/A)		Gender ☐ Male ☐ Female	Date of Birth (Month/Day/Year) / /	Age
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? ☐ Yes ☐ No	
If Over Age 25, is Dependent Disabled? ☐ Yes ☐ No		Product Selection(s) ☐ Medical ☐ Vision ☐ Dental		

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ☐ Child ☐ Step-child ☐ Adopted* ☐ Other*	
Social Security Number (If no SS#, write N/A)		Gender ☐ Male ☐ Female	Date of Birth (Month/Day/Year) / /	Age
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? ☐ Yes ☐ No	
If Over Age 25, is Dependent Disabled? ☐ Yes ☐ No		Product Selection(s) ☐ Medical ☐ Vision ☐ Dental		

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custody/legal papers to support dependent eligibility.

OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date / /	Name of Policyholder
Policyholder Date of Birth / /	Relationship to Policyholder	Policy Number	Policyholder Employment Status ☐ Active ☐ Retired Date of Retirement: / /

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement? ☐ Yes ☐ No
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								☐ Yes ☐ No
								☐ Yes ☐ No
								☐ Yes ☐ No

IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

I understand that this form enrolls those eligible persons listed above in the Product as described in the agreement between Highmark Delaware 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. 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.

Employee/Contract Holder Signature

Date

Please fax Member Change Forms to (800) 290-3301 or mail the forms to one of the following addresses:

<https://www.enrollmentandbilling@highmark.com>

Membership Department
P.O. Box 890172
Camp Hill, PA 17089-0172

To find more information about our benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4108.

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefits determinations.

We are committed to providing outstanding services for our applicants and members. If you require special assistance, including accommodations for disabilities or limited English proficiency, please call the number on the back of your Member ID card to request these free services (TTY/TDD users may call 711).

Highmark Blue Shield (Highmark), Highmark Health Insurance Company (HHIC) and Highmark Benefits Group (HBG) are independent licensees of the Blue Cross Blue Shield Association. Insurance may be provided by HHIC or HBG. Health care plans are subject to terms of the benefit agreement.