

# Member Change Form

**Instructions:** Please complete in ink and return to your employer. Use extra sheets of paper if necessary. Anthem's Primary Care Physician (PCP) listings can be obtained through [www.anthem.com](http://www.anthem.com).  
**IF ADDING AN ELIGIBLE DEPENDENT PLEASE COMPLETE ENROLLMENT APPLICATION.**

**MCF**

**GROUP INFORMATION – This section should be completed by Group Administrator (if applicable)**

<input type="checkbox"/> HealthKeepers, Inc. (HMO)	<input type="checkbox"/> Priority Health Care, Inc. (HMO)	Effective date of change (subject to plan guidelines)
<input type="checkbox"/> Peninsula Health Care, Inc. (HMO)	<input type="checkbox"/> Anthem Blue Cross and Blue Shield (Par/PPO)	
Group Name	Group Number	Mo    Day    Year

**MEMBER INFORMATION** (please print or type)

Member identification number (Please provide information as shown on your ID card):

Last name	First name	M.I.
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- Personal Data Change**  
*(Please check the appropriate boxes and complete only those items requesting to be changed as of the effective date noted above. For social security number, attach appropriate documentation.)*
- Name Change (employee only)       Address Change  
 Name Correction (employee & dependent)       Phone Number Change  
 Social Security Number Correction

New name - Last name	First Name	M.I.
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New address - Street	Apt. #
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City	State	Zip
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New daytime phone (with area code) (    )    -    -    -    -    -	New evening phone (with area code) (    )    -    -    -    -    -
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Correction of social security number	
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- Change in Type of Membership**     
  Remove all dependent(s)     
  Remove child (please provide child's last and first name): \_\_\_\_\_  
 Remove spouse

**Primary Care Physician (PCP) Change**

Member's first name	Current physician	New physician	Current patient?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

- Cancellation of Coverage**     
  Left organization     
  Divorced     
  Moved out of service area     
  Deceased

**Authorization**

I authorize the changes, as shown above, to be made by the requested effective date. I authorize my employer to make changes in payroll deductions if required by the health coverage changes I have made. I understand that these changes are effective only after they are accepted by my employer and received by the health care company.

Member signature	Date	Home Telephone
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Employer or Group Administrator signature (if applicable)	Date	Telephone
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*For use by current members only. This is not an application. A new employee must complete an enrollment application.*