Change form

Priority Health

Member changes must be received by Priority Health within 31 days of the event.
Priority Health · MS 2275 · 1231 E. Beltline NE, Grand Rapids, MI 49525 · Fax to: 616.942.5242

This form should be used for terminations of subscriber or dependent, demographic updates to a subscriber or dependent, and changes to plans.

Member information

Member's last name	First name	Middle initial	Social Security number — —	Member ID number
Email		Phone		

Are you or any of your dependents covered under another insurance plan? If yes, please provide the following information:	Other carrier information	Effective date of coverage
☐ **Name change** For: ☐ Member ☐ Dependent	New last name	First name

☐ **Address/phone change** For: ☐ Member ☐ Dependent	Street	City, State	ZIP	Phone

☐ **Dependent information (if you have more than 3 dependent changes, complete an additional change form)**

1	Last name	First name	Middle initial	Social Security number — —	Race/Ethnicity (optional)	Sex ☐ Male ☐ Female	
	Birth date / /	Relation to member	Address	City, State	ZIP		
	☐ Covered under another insurance plan? If different from above, please provide the following information:		Other carrier information	Effective date of coverage			
	Has this dependent ever seen this provider? ☐ Yes ☐ No	Primary care provider (REQUIRED for HMO & POS)	PCP address				
2	Last name	First name	Middle initial	Social Security number — —	Race/Ethnicity (optional)	Sex ☐ Male ☐ Female	
	Birth date / /	Relation to member	Address	City, State	ZIP		
	☐ Covered under another insurance plan? If different from above, please provide the following information:		Other carrier information	Effective date of coverage			
	Has this dependent ever seen this provider? ☐ Yes ☐ No	Primary care provider (REQUIRED for HMO & POS)	PCP address				
3	Last name	First name	Middle initial	Social Security number — —	Race/Ethnicity (optional)	Sex ☐ Male ☐ Female	
	Birth date / /	Relation to member	Address	City, State	ZIP		
	☐ Covered under another insurance plan? If different from above, please provide the following information:		Other carrier information	Effective date of coverage			
	Has this dependent ever seen this provider? ☐ Yes ☐ No	Primary care provider (REQUIRED for HMO & POS)	PCP address				

Authorization

I authorize Priority Health to make the changes indicated above for my dependents and me. I understand that Priority Health may request pertinent sworn statements if needed and that I must sign and date this form before it will be processed. *Priority Health requires proper handling of personal health information for our members. Details of our confidentiality policies and procedures are available upon request.*

x _____
Member signature Date

Completed by employer

☐ **New plan change?** ☐ **HMO** ☐ **POS** ☐ **PPO** ☐ **HRA** ☐ **HSA** ☐ **PriorityWell Choice Benefits** **Plan option (if applicable)** ☐ **High** ☐ **Mid** ☐ **Low**

Employer name	Group number	Sub group number	Sub group ☐ New ☐ Existing	Class	Class ☐ New ☐ Existing
Employer/representative signature			Date / /		
Reasons for additions ☐ Marriage ☐ Birth ☐ Adoption (proof required) ☐ Loss of other coverage ☐ Open enrollment ☐ Court order (proof required) ☐ Other _____			Effective date / /		
Reasons for dependent termination ☐ Marriage of dependent ☐ Divorce ☐ Death ☐ Lost eligibility ☐ Other _____			Date participant notified of coverage termination / /		Date coverage ended / /
Reason for termination of entire contract ☐ Terminated employment ☐ Lay off ☐ Leave of absence ☐ Changed health plans ☐ Moved out of the area ☐ Death ☐ COBRA terminated ☐ Dissatisfied ☐ Other _____			Date participant notified of coverage termination / /		Date coverage ended / /