

Member information							
Member legal last name		Legal first name		Middle initial	Social Security number — —	Member ID number	Sex male Female
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	Legal last name		Legal 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)		Priority Health Provider ID PH provider ID can be found on priorityhealth.com/findadoc		PCP address	
2	Legal last name		Legal 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)		Priority Health Provider ID PH provider ID can be found on priorityhealth.com/findadoc		PCP address	
3	Legal last name		Legal 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)		Priority Health Provider ID PH provider ID can be found on priorityhealth.com/findadoc		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. <i>Priority Health requires proper handling of personal health information for our members. Details of our confidentiality policies and procedures are available upon request.</i>	
x _____ Member signature	_____ Date

Completed by employer	New plan change?	HMO	POS	PPO	HRA	HSA	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 / /	