Member Change Form

Instructions: Please complete in ink and return to your employer. Use extra sheets of paper if necessary. Primary Care Physician (PCP) listings can be obtained through 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)

❑ **HealthKeepers, Inc. (POS)** ❑ **Anthem Blue Cross and Blue Shield (PPO)**

Effective date of change (subject to plan guidelines)

Mo Day Year

Group Name

Group Number

MEMBER INFORMATION (please print or type)

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

Last name First name M.I.

Employee Social Security no.* (required)

❑ ***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)

❑ **Name Correction** (employee & dependent)

❑ **Social Security Number Correction**

❑ **Address Change**

❑ **Phone Number Change**

New name - Last name First Name M.I.

New address - Street Apt. #

City State Zip

New daytime phone (with area code) ( ) –

New evening phone (with area code) ( ) –

Correction of social security number – –

❑ ***Change in Type of Membership***

❑ **Remove all dependent(s)**

❑ **Remove spouse**

❑ **Remove child** (please provide child's last and first name): ____________________

❑ ***Primary Care Physician (PCP) Change***

Member's first name	Current physician	New physician	Current patient?
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

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

W-9 Certification Language

As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because (a) I am exempt from backup withholding or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified m me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

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

Employer or Group Administrator signature (if applicable) Date Telephone

*Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. are required by the Internal Revenue Service to collect this information.

For use by current members only. This is not an application. A new employee must complete an enrollment application.

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. are independent licensees of the Blue Cross Blue Shield Association.

®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

170006 (1/15)