

# Health Tradition Health Plan

Send to: Health Tradition Health Plan  
c/o MMSI  
4001 41st Street NW  
Rochester, MN 55901-8901

Employer Group Name: \_\_\_\_\_ Effective Date of Change: \_\_\_\_\_

**Employee Information**

Name: \_\_\_\_\_  
Last
First
M.I.

Address: \_\_\_\_\_

City/State/ZIP Code: \_\_\_\_\_

Employee Social Security No. or member ID no. (required): \_\_\_\_\_

New telephone no.: Home ( \_\_\_\_\_ ) \_\_\_\_\_ Work ( \_\_\_\_\_ ) \_\_\_\_\_

Check if name change      Previous Name: \_\_\_\_\_

Check if new address      Previous Address: \_\_\_\_\_

**Dependent Changes**

*When adding a dependent, you must enter Social Security Number and information about his or her primary care provider.*

CHECK ONE		NAME			BIRTH DATE			SEX	Relationship to Applicant	CHECK REASON						
ADD	REMOVE	LAST	FIRST	M.I.	MO.	DAY	YR.	F		M	Date of Marriage	Birth of Child	Date of Divorce	Return from Active Duty	Loss of Coverage	
		Social Security No. _____			Primary Care Provider Name/Location _____											
		Social Security No. _____			Primary Care Provider Name/Location _____											
		Social Security No. _____			Primary Care Provider Name/Location _____											

*Adult children are eligible for coverage up to the end of the month in which they turn 26, as long as they are not eligible for health insurance through their employer or if they are covered by health insurance through their employer, the amount of their premium contribution is more than the additional premium amount to insure the adult child on this policy.*

**Other Health Insurance**

On the date this change will take effect, will you or any family member(s) be covered by any other group medical insurance (not replacing this plan), including Medicare?  Yes  No

*If yes, please complete this information:*

Name of person with other insurance/plan \_\_\_\_\_ Type of coverage:  Single  Family

Please list names of covered family members \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Group No. \_\_\_\_\_ Certificate No. \_\_\_\_\_

Policy: Effective date \_\_\_\_\_ Termination date \_\_\_\_\_ Will you be terminating coverage?  Yes  No

Is this a group policy/plan offered through an employer?  Yes  No If no, what is it offered through? \_\_\_\_\_

**Coverage Changes**

**Change of contract status (single, family, employee + spouse, employee + children, retirement, etc.)**

From \_\_\_\_\_ To \_\_\_\_\_

Change from eligible employee to state/federal continuation COBRA.

*(Please attach copy of signed member continuation form.)*

Change from eligible dependent to state/federal continuation COBRA.

*(Please attach copy of signed member continuation form.)*

Change of plan option (at renewal date only) \_\_\_\_\_

**Termination**

To cancel coverage, check here: \_\_\_\_\_ Last day worked: \_\_\_\_\_

- Reason for termination:  Left employment  Moved out-of-area  Cancellation  Deceased  
 Reduction in hours  Other  Non-payment of COBRA premium

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic, medically related facility, insurance or reinsuring company, or third party administrator having medical information about myself or my minor children to disclose such information to Health Tradition Health Plan, its third-party administrator, other insurers/plans (including Centers for Medicare & Medicaid Services) and other healthcare providers as necessary for the provision or evaluation of services, the determination of claims or requests for services or benefits under my enrollment, or the administration of the plan. This authorization shall be valid for two and one-half years from the date shown below. I agree that a photographic copy of this authorization shall be valid as the original. I or my authorized representative can request and receive a copy of this authorization from the Plan at any time I am enrolled with this Plan. I or my authorized representative have the right to revoke this authorization in writing at any time.

\_\_\_\_\_  
Employee signature\_\_\_\_\_  
Date Signed\_\_\_\_\_  
Spouse Signature (if to be insured)\_\_\_\_\_  
Date Signed\_\_\_\_\_  
Adult Dependent Signature\_\_\_\_\_  
Date Signed\_\_\_\_\_  
Adult Dependent Signature\_\_\_\_\_  
Date Signed

I HEREBY apply for amendment of my enrollment application. I attest that, to the best of my knowledge, the information submitted on this form is correct. If authorized representative is signing, attach authorized representative documentation.

It is mutually agreed as follows: That these changes shall not become effective unless and until accepted by Health Tradition Health Plan. That this Member Change form will become a part of my original application and, if accepted, will be subject to terms in effect with my benefit plan.

\_\_\_\_\_  
Print Name\_\_\_\_\_  
Date Signed\_\_\_\_\_  
Authorized Signature

*(Employee or Authorized Representative)*  
*(If termination – Employer Representative)*

\_\_\_\_\_  
Relationship to Employee\_\_\_\_\_  
Employer Group Name