HEALTH TRADITION

Please complete, print and submit. Reset Form Print

Member Change Form

Send to: Health Tradition Health Plan
PO Box 21171
Eagan, MN 55121

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.

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

Termination Of Coverage Attestation

Please complete this section if you or a dependent are requesting enrollment due to a loss of coverage.

Have you or any of your dependents had coverage under any other health insurance within the past 30 days?
❑ Yes ❑ No

If so, with what company and what kind of policy? Company _____

Kind of policy _____

What are your dates of coverage under the other policy? (mm/dd/yy)? Start ____/ ____ / ____ End ____/ ____ / ____
(If you are still covered under this plan, leave "END" blank.)

Name of current insurance company: _____

Name of individuals covered: _____

Your identification and group number with current insurance company: _____

Reason for termination: _____

I hereby attest that my previous health insurance coverage was terminated on ____/ ____ / ____ .
I understand that inaccuracies in reporting this date could constitute fraud or misrepresentation and could result in rescission of my health insurance plan with Health Tradition and potential other legal consequences.

Signature Signature Required _____ Date _____

Printed Name _____

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.

Signature Required _____ _____
Employee Signature Date Signed

Signature Required _____ _____
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

Signature Required _____ _____ _____
Authorized Signature Relationship to Employee Employer Group Name
(Employee or Authorized Representative)
(If termination – Employer Representative)