



CHARTER HEALTH PLAN
A big idea for small business

Employee Change Request

Please read instructions on opposite page before completing this form. Print clearly.

1. Employee Information					
Group Name: _____		For Charter Staff Use Only			
Charter Member ID #: _____		Effective Date: _____		Group Number: _____	
Last Name, First, MI:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Date of Birth: / /	
Home Address:			Apt. #:	City, State:	Zip Code:
2. Type of Activity					
Date of Event: ____/____/____ Reason: _____					
<input type="checkbox"/> Add Spouse		<input type="checkbox"/> Remove Spouse			
<input type="checkbox"/> Add Dependent		<input type="checkbox"/> Remove Dependent			
<input type="checkbox"/> Name Change from: _____ to: _____					
<input type="checkbox"/> Other: _____ Reason: _____					
3. Detailed Employee & Dependent Information				# of Family Members _____	
	Last Name, First, MI	Gender M F	Date of Birth MM/DD/YY	Social Security #	Primary Care Physician (PCP)
Spouse		<input type="checkbox"/> <input type="checkbox"/>	/ /		
Children		<input type="checkbox"/> <input type="checkbox"/>	/ /		
Attach Sheet to List Additional Children		<input type="checkbox"/> <input type="checkbox"/>	/ /		
		<input type="checkbox"/> <input type="checkbox"/>	/ /		
		<input type="checkbox"/> <input type="checkbox"/>	/ /		

If enrolling spouse and/or dependent(s), please complete health questionnaire.

4. Dependent Information: N/A

Do any of the dependents listed in Section 3 live at another address? Yes No

If yes, who and at what address?

Name:

Address:

If any dependent's last name is different from yours, please explain the circumstances:

5. Other Coverage Information: N/A

Have any of the dependents listed in Section 2 had insurance coverage within the last 12 months? Yes No

Is the coverage still active? Yes No If Yes, what is the Effective Date? __/__/____ If No, what is the End Date? __/__/____

If coverage is still active, please provide the following information along with a copy of your insurance ID card:

Person(s) Covered	Policy Holder Name	Insurance Company	Policy Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please include a copy of the Certificate of Portability if coverage has ended. If your dependent was covered under another health plan before enrolling with your current health plan you may be able to reduce or remove limitations on pre existing conditions. If your dependent did not have more than a 63 day lapse between prior coverage and current coverage, you may receive credit toward the time limit for a pre-existing condition. If your dependent were covered under another health plan before enrolling with your current health plan you may be able to reduce or remove limitations on pre existing conditions.

6. Enrolling Employee Signature:

I certify that all the information supplied on this application is true and complete.

Employee's Signature:

Optional E-Mail:

Date:

Change Request Instructions

Section 1 - Employee Information: Complete all information in order for your application to be processed.

Section 2 - Type of Activity: To indicate whether you are Adding or Removing self and/or dependents, check the appropriate Add or Remove boxes. Check box(es) indicating reason(s) for submitting form, Date of Event and Reason (where requested).

Section 3 - Detailed Employee and Dependent Information: Print your full name along with the name(s) of your dependent(s), if applicable. Choose a primary care physician (PCP) from the available provider directory and write the physician's full name in the space provided.

Section 4 - Dependent Information: Complete these sections for all new applicants.

Section 5 - Other Coverage Information: Complete these sections for all new applicants.

Section 6 - Employee Signature: The Employee must sign and date the application for it to be processed.