group health Cooperative of eau claire

Member Change Form

Employer Name:	Plan ID:
Effective Date of Change:	

Employee Information/Changes

Last Name:	First Name:	Middle Initial:

Street Address:	City:	State:	ZIP:

Social Security #:	Date of Birth:	Member ID #:

Home Phone:	Work Phone:	Cell Phone:

Email Address:

☐ **Cancel all coverage** (employee and any dependents) – Reason: Date of Event:

☐ **Name change** – Previous name:

☐ **New address** – Previous address:

☐ **New phone number** – Previous phone number:

☐ **New email address** – Previous email address:

Other Changes

☐ Change from active employee to state continuation/federal COBRA effective:
(Please attach a copy of signed Member Continuation Form)

☐ Eligible for Medicare coverage (attach copy of Medicare ID card):

Name: Medicare ID #:

Part A Effective Date: Part B Effective Date:

Reason: ☐ Age 65 or older ☐ Disability ☐ End Stage Renal Disease – onset date:

Other (specify):

Other Insurance Information

Does anyone named in this form have other medical group insurance coverage? ☐ Yes ☐ No

If yes, who?

Effective Date:	Plan ID:	Insurer:

Attach Certificate of Creditable Coverage.

Signature

Employee/Employer Name (please print):

Employee/Employer Signature:	Date:

Form must be submitted to Group Health Cooperative of Eau Claire within the timeframes as specified in your schedule of benefits.

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Member Change Form

Dependent Information/Changes

☐ Add ☐ Remove ☐ Other

Reason and Date

☐ Marriage: ☐ Birth: ☐ Lost Other Coverage: ☐ Divorce:

☐ Adoption: ☐ Death: ☐ Other (specify):

Last Name:	First Name:	Middle Initial:	Date of Birth:
Relationship to Employee:	Social Security #:	Email Address:	

Home Phone:	Work Phone:	Cell Phone:
Does the dependent named within this form live with you at the address listed above? If "no," please list the dependent's current address: ☐ Yes ☐ No		Member ID #:

Street Address:	City:	State:	ZIP:

Preferred Language: ☐ English ☐ Spanish ☐ Hmong ☐ Choose not to disclose ☐ Other (specify):

Sex Assigned at Birth:
- ☐ Male
- ☐ Female

Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Trans male/Trans man
- ☐ Trans female/Trans woman
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Other:_____
- ☐ Choose not to disclose

Race/Ethnicity:
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Some other race (specify):
- ☐ Choose not to disclose

- ☐ **Name change** – Previous name:
- ☐ **New address** – Previous address:
- ☐ **New phone number** – Previous phone number:
- ☐ **New email address** – Previous email address:

Other Changes

☐ Change from eligible dependent to state continuation/federal COBRA effective:
(Please attach a copy of signed Member Continuation Form)

☐ Eligible for Medicare coverage (attach copy of Medicare ID card):

Name: Medicare ID #:

Part A Effective Date: Part B Effective Date:

Reason: ☐ Age 65 or older ☐ Disability ☐ End Stage Renal Disease – onset date:

Other (specify):

Add additional pages as needed.