SecurityHealth Plan℠
Promises kept, plain and simple.®

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**Subscriber**

# Change Request

| Employer name | Effective date _____ |
|---|---|

| Subscriber last name | First name | MI | Subscriber number |
|---|---|---|---|
| Spouse's last name | Spouse's first name | MI | Group number |

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced/Separated

**Check and complete changes that apply and sign below.**

☐ **Name change**
Change from | Change to | Reason for change
If married, spouse's name | Date of marriage (m/d/y) / / | Date of divorce (m/d/y) *If applicable* / /

☐ **Phone number change**
Change to ( ) ☐ Home ☐ Work ☐ Cell

☐ **Email address change**
Change to

☐ **Address change**
Change applies to: ☐ Residence address ☐ Mailing address
Street/Route | Apartment number
City | State | ZIP code | County

☐ **Primary care provider**
Name (first and last) | Facility/Clinic location where primary care is received

☐ **Plan change**
Group number | Plan description

☐ **Cancel employer group subscriber coverage**
Cancellation date (m/d/y) *List first date of ineligibility requested* / /
Reason cancelled

☐ **Cancel an individual policy**
Requested cancellation date (m/d/y) / /

☐ **Addition of spouse or dependent(s)**

**Note to Select subscribers:** If you are adding a spouse, your spouse will need to complete an *Application for Individual Medical Insurance*. Adding or deleting a spouse or dependent will increase or decrease your current monthly premium. Include a check or money order for the additional premium needed to add a spouse or dependent(s).

| Name | | | | Gender | | Date of Birth | | | Relationship to Subscriber | Social Security Number | Office Use Only |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Last | Former Last/ Maiden | First | MI | M | F | Mo | Day | Yr | | | Member Identifier |
| | | | | ☐ | ☐ | | | | | | |
| Primary care provider name (first and last) | | | | Facility/Clinic location where primary care is received | | | | | | | |
| | | | | ☐ | ☐ | | | | | | |
| Primary care provider name (first and last) | | | | Facility/Clinic location where primary care is received | | | | | | | |

Date added ____ /____ /____ Reason added _____

☐ **Deletion of dependent(s)**

| Name | | | Date of Birth | | | Termination Date | Office Use Only |
|---|---|---|---|---|---|---|---|
| Last | First | MI | Mo | Day | Yr | | Member Identifier |
| | | | | | | | |
| | | | | | | | |

Reason deleted _____

**Subscriber signature** _____ Date (m/d/y) _____ /_____ /_____
(Signature required for any change)

  