MOUNTAIN HEALTH CO-OP
PO BOX 5358
HELENA MT 59604
PHONE (855) 447-2900
WWW.MHC.COOP

Change of Status for Individual Coverage

Primary Member Information		
First Name	**Middle Name**	**Last Name**
Date of Birth (mm/dd/yyyy)	**SSN or MHC Member ID**	**Daytime Phone**

Member or Dependent(s) Cancellation – list all members being cancelled	
First Name	**Last Name**
Effective Date of Cancellation – will be last day of the month	

Member or Dependent(s) Addition			
First Name	**Last Name**	**Date of Birth (mm/dd/yyyy)**	**Gender** ☐ Male ☐ Female
Social Security Number	Relationship to Member ☐ Spouse/ Domestic Partner ☐ Dependent Child	Tobacco User ☐ Yes ☐ No	

What is the qualifying event for this Addition?
☐ Marriage/Divorce ☐ Birth/Adoption ☐ Relocation to a new ZIP code, county, or state ☐ Change in income ☐ Changes to citizenship or immigration status ☐ Loss of other coverage (e.g. employer coverage, Medicaid or CHIP, COBRA Expiration) ☐ Release from incarceration ☐ Return from Military Service ☐ Other _____

☐ Effective Date of the above change [mm/dd/yyyy] _____

Name Change	
Old Name	**New Name**

Address/Phone/Email Change
New Mailing Address Street or P.O. Box, City, State, Zip
New Billing Address *(if different from mailing)* Street or P.O. Box, City, State, Zip
New Email Address *(new email address required if primary member is being cancelled/removed from policy)*
New Phone Number

Billing Change (Select All That Apply)	
☐ **Billing Address Change** *Complete billing address change on page 1.*	☐ **Electronic Billing to Paper Billing** *Complete billing address change on page 1.*
Authorization Signature of Change	
I authorize MHC to make the changes to my policy as indicated above. The effective date for the changes or cancellation of family members will be assigned by MHC.	
Signature of Member	
Signature of Guardian if under 18 years of age	

Mail/Email/Fax Completed Form to:

Mountain Health CO-OP
PO Box 5358
Helena, MT 59604

call 1-855-447-2900 for fax info
email: memberservice@mhc.coop