CHANGE OF STATUS FOR GROUP COVERAGE

Subscriber Information

First Name	**Middle Name**	**Last Name**

Date of Birth (mm/dd/yyyy)	**MHC Health Plan Subscriber ID**	**Daytime Phone**

Purpose (Check all that apply and complete the corresponding sections):

[ ] Name Change
[ ] Address or Email Change
[ ] Subscriber or Dependent(s) Addition/Cancellation

Effective Date of the above change (m m / d d / y y y y) _____/_____/_____

Name Change

New Name **(**Last Name, First Name, MI)

Last _____ First _____ MI_____

Old Name **(**Last Name, First Name, MI)

Last _____ First _____ MI_____

Address Change

New Mailing Address

Street_____ City_____ State_____ Zip_____

New Billing Address (if different than mailing address)

Street_____ City_____ State_____ Zip_____

New Email Address *(new email address required if primary subscriber is being cancelled/removed from policy)*

Subscriber or Dependent(s) Addition/Cancellation

First Name	**Last Name**	**Date of Birth (mm/dd/yyyy)** ___/___/_____	**Gender** [ ] Male [ ] Female

Social Security Number	Relationship to Applicant	Select One	Tobacco User	Willing to participate in cessation program?
	[ ] Subscriber [ ] Spouse/ Domestic Partner [ ] Dependent Child	[ ] Addition [ ] Cancellation [ ] Cancel family policy	[ ] Yes [ ] No	[ ] Yes [ ] No

What is the qualifying event for this Addition or Cancellation?

[ ] Marriage/Divorce [ ] Birth/Adoption [ ] Turning 26 years-of-age
[ ] Loss of other coverage (e.g. Medicaid, CHIP, COBRA Expiration)
[ ] Return from Military Service [ ] Other _____

[ ] Effective Date of the above change m m / d d /yyyy _____/_____/_____

Subscriber or Dependent(s) Addition/Cancellation

First Name	**Last Name**		**Date of Birth (mm/dd/yyyy)** ___/___/_____	**Gender** [ ] Male [ ] Female
Social Security Number	Relationship to Applicant [ ] Spouse/ Domestic Partner [ ] Dependent Child	Select One [ ] Addition [ ] Cancellation [ ] Cancel family policy	Tobacco User [ ] Yes [ ] No	Social Security Number

What is the qualifying event for this Addition or Cancellation?

[ ] Marriage/Divorce [ ] Birth/Adoption [ ] Turning 26 years-of-age
[ ] Loss of other coverage (e.g. Medicaid, CHIP, COBRA Expiration)
[ ] Return from Military Service [ ] Other _____

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

Subscriber or Dependent(s) Addition/Cancellation

First Name	**Last Name**		**Date of Birth (mm/dd/yyyy)** ___/___/_____	**Gender** [ ] Male [ ] Female
Social Security Number	Relationship to Applicant [ ] Spouse/ Domestic Partner [ ] Dependent Child	Select One [ ] Addition [ ] Cancellation [ ] Cancel family policy	Tobacco User [ ] Yes [ ] No	Social Security Number

What is the qualifying event for this Addition or Cancellation?

[ ] Marriage/Divorce [ ] Birth/Adoption [ ] Turning 26 years-of-age
[ ] Loss of other coverage (e.g. Medicaid, CHIP, COBRA Expiration)
[ ] Return from Military Service [ ] Other _____

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

Authorization Signature of Change

I authorize Montana Health Cooperative to make the changes to my policy as indicated above. The effective date for the changes to a Primary Care Physician selection or cancellation of family members will be assigned by MHC.

Signature of Subscriber

Signature of Guardian if under 18 years of age