Montana Health CO-OP
P.O. Box 5358
Helena, MT 59604
855-488-0621

CHANGE OF STATUS FOR GROUP OR INDIVIDUAL COVERAGE

Subscriber Information

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

Date of Birth (mm/dd/yyyy)	**SSN or 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
[ ] Billing Change
[ ] **Effective Date of the above change [mm/dd/yyyy] [/ /]**

Name Change

New Name	Last Name, First Name, MI
Old Name	Last Name, First Name, MI

Address 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 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 [ ] Spouse/ Domestic Partner [ ] Dependent Child	Select One [ ] Addition [ ] Cancellation [ ] Cancel family policy	Tobacco User [ ] Yes [ ] No	Willing to participate in cessation program? [ ] Yes [ ] No

What is the qualifying event for this Addition or Cancellation?

[ ] Marriage/Divorce [ ] Birth/Adoption [ ] Turning 26 years-of-age [ ] Relocation to a new ZIP Code, county, or state
[ ] Chapter 11 Bankruptcy [ ] Changes to citizenship or immigration status [ ] Court Order 26 years-of-age
[ ] 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] [/ /]

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	Tobacco User [ ] Yes [ ] No	Willing to participate in cessation program? [ ] Yes [ ] No

What is the qualifying event for this Addition or Cancellation?

[ ] Marriage/Divorce [ ] Birth/Adoption [ ] Turning 26 years-of-age [ ] Relocation to a new ZIP Code, county, or state
[ ] Chapter 11 Bankruptcy [ ] Changes to citizenship or immigration status [ ] Court Order 26 years-of-age
[ ] 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] [/ /]

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	Tobacco User [ ] Yes [ ] No	Willing to participate in cessation program? [ ] Yes [ ] No

What is the qualifying event for this Addition or Cancellation?

[ ] Marriage/Divorce [ ] Birth/Adoption [ ] Turning 26 years-of-age [ ] Relocation to a new ZIP Code, county, or state
[ ] Chapter 11 Bankruptcy [ ] Changes to citizenship or immigration status [ ] Court Order 26 years-of-age
[ ] 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] [/ /]

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 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.

Due to your change in status you may now be eligible for a government subsidy. If interested in receiving more information about this subsidy please provide your estimated Modified Adjusted Gross household income
$_____

Signature of Subscriber

Signature of Guardian if under 18 years of age

Mail Completed Form to:
Montana Health CO-OP
P.O. Box 5358
Helena, MT 59604

or email to:
memberservice@mhc.coop