



MEMBERSHIP AND RECORD CHANGE FORM

(Please print or type. Prepare in duplicate.)

SOC. SECURITY NO.	SUBSCRIBER'S LAST NAME	FIRST NAME	INITIAL
HAP NUMBER	SUBSCRIBER'S CURRENT ADDRESS CHECK IF NEW <input type="checkbox"/>	CITY	STATE ZIP
PHONE NUMBER	GROUP NAME	GROUP NUMBER	

REQUEST FOR MEMBERSHIP CHANGE

ADD MEMBERS TO CONTRACT (ADDITIONS)

	DATE OF EVENT			LAST NAME	FIRST NAME	SEX		SOC. SECURITY NO.	DATE OF BIRTH		
	MO.	DAY	YR.			M	F		MO.	DAY	YR.
<input type="checkbox"/> MARRIAGE TO											
<input type="checkbox"/> BIRTH OF CHILD											
<input type="checkbox"/> STEPCCHILD											
<input type="checkbox"/> CHILD BY LEGAL ADOPTION											
<input type="checkbox"/> CHILD BY LEGAL GUARDIANSHIP (WARD)											
<input type="checkbox"/> PRINCIPAL SUPPORT OF CHILD											
<input type="checkbox"/> OTHER											

ADDITIONAL INFORMATION

REMOVE MEMBERS FROM CONTRACT (DELETIONS)

	DATE OF EVENT			LAST NAME	FIRST NAME	SEX		SOC. SECURITY NO.	HAP NUMBER
	MO.	DAY	YR.			M	F		
<input type="checkbox"/> DEATH OF DEPENDENT									
<input type="checkbox"/> DIVORCE FROM									
<input type="checkbox"/> MARRIAGE OF MINOR OR DEPENDENT									
<input type="checkbox"/> OTHER									

MAIL GROUP CONVERSION ADDRESS CITY STATE ZIP
CONTRACT TO THIS ADDRESS

ADDITIONAL INFORMATION

AFTER THE CHANGES (ADDITIONS/DELETIONS) I WILL HAVE THE FOLLOWING MEMBERS LISTED ON MY CONTRACT

LAST NAME	FIRST NAME	LAST NAME	FIRST NAME	LAST NAME	FIRST NAME	LAST NAME	FIRST NAME
LAST NAME	FIRST NAME	LAST NAME	FIRST NAME	LAST NAME	FIRST NAME	LAST NAME	FIRST NAME

CHECK IF ANY MEMBERS ON THE CONTRACT ARE ELIGIBLE FOR COVERAGE UNDER PUBLIC ACT 275 (ATTACH A SWORN STATEMENT)

REQUEST FOR RECORD CHANGE

ENROLL THE FOLLOWING MEMBERS IN THE HEALTH ALLIANCE PLAN COMPLEMENTARY COVERAGE	BIRTH DATE			MEDICARE CLAIM NO.	EFFECTIVE DATES						
	MO.	DAY	YR.		HOSP. INS. (A)			MED. INS. (B)			
					MO.	DAY	YR.	MO.	DAY	YR.	
SUBSCRIBER'S LAST NAME FIRST NAME											
SPOUSE'S LAST NAME FIRST NAME											
OTHER - LAST NAME FIRST NAME											

CHANGE OF NAME LAST NAME FIRST NAME MIDDLE INITIAL HAP NUMBER

DEATH OF SUBSCRIBER OCCURED ON MO. DAY YR. BILL FAMILY AT THE ABOVE ADDRESS

I HEREBY REQUEST CANCELLATION OF MY COVERAGE FOR MYSELF AND ALL DEPENDENTS SUBSCRIBER'S SIGNATURE (DON'T USE FOR TERMINATION OF EMPLOYMENT)

SEND DUPLICATE I.D. CARDS SEND DUPLICATE COPIES OF HEALTH ALLIANCE PLAN'S CONTRACTS AND RIDERS

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO MY KNOWLEDGE AND BELIEF:

SUBSCRIBER'S SIGNATURE	MO.	DAY	YR.	WITNESS' SIGNATURE	MO.	DAY	YR.
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