

Health Plan Change Request Form

Member Information

Full Name

Member ID

Date of Birth

Email Address

Phone Number

Address

Current Health Plan Details

Current Plan Name

Current Plan Effective Date

Requested Change

Type of Change

Requested/New Plan Name

Reason for Change

Dependent(s) Information (If Applicable)

List Dependents to Add/Remove (Full Name, DOB, Relationship)

Member Signature

Date

** Please submit this form to your plan administrator. Additional documentation may be required.*