



MEMBER CHANGE FORM

Membership Department
P.O. Box 890172
Camp Hill, PA 170897

In order to process this Change Form, the name and Member Identification Number of the Employee/Contract Holder must be completed in the space provided.

Employer Name, Employer Telephone Number, Association Name (if applicable) PA Medical Society, Group Number, Employee (Last), (First), (M.I.), Member Identification Number, Effective Date of Change, Please give a brief description of the changes to be made.

COMPLETE ONLY THE SECTIONS THAT APPLY TO CHANGES IN MEMBER RECORDS.

Street Address, City, State, Zip, Home Phone, Work Phone, Hire Date, Group No., Report Code, Change enrollment status to: Single, Parent/Child, Insured and Spouse/Domestic Partner, Parent/Children Family, Type of Change, Previous Member Identification Number, Current Member Identification Number, Previous Last Name, Current Last Name, First Name Middle Initial, Sex, Member Status, Birthdate, Primary Care Physician Name, Existing Patient?, Marriage Date

Please check one if applicable (if additional space is required, attach a separate sheet). If you [], your spouse/domestic partner [], or dependent(s) [], are enrolled in another Program or Medicare, please give the following information: Name of Insurance Carrier, Group No., Effective Date, Name of Policy Holder, Policy Number, Relationship to Highmark Policy Holder, Policy Holder Date of Birth, Policy Holder Employment Status, MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits, Health Insurance Claim Number, Part A Effective Date, Part B Effective Date, Part D Effective Date, Why are you eligible for Medicare?, Do you have a Medicare Supplement or other coverage that complements Medicare?

To the best of my knowledge and belief, the information provided on this application is true and correct. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that this form enrolls those eligible persons listed above in the Medical Plan as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form

or they will not be covered. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment, and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

Authorization Employer Signature

Date

Employee Signature

Date