Anthem Group Health Insurance

Member Change Form

Used to add someone to your existing health insurance policy

EMPLOYEE INFORMATION

Your name: _____

Date this form submitted to HR: _____

Your signature: _____

REASON FOR APPLICATION

☐ Marriage. Date of Marriage: _____

☐ Birth. Date of Birth: _____

☐ Adoption. Date of Adoption/placement: _____

☐ Open Enrollment _____

☐ Loss of Coverage Elsewhere. Date coverage lost: _____

EFFECTIVE DATE

For this change to be effective the date of the event above, and for the premium to be paid with pre-tax dollars, you must send this form (with any other required information) within 31 days of the event.

INFORMATION ON MEMBER(S) TO BE ADDED

You may cover your spouse, your children age 26 or younger (newborn, natural child, child placed with you for adoption, a stepchild or any other child for whom you have legal guardianship or court ordered custody.

Full Name: _____

Relationship: _____ Sex: _____

SSN: _____ DOB: _____

Full Name: _____

Relationship: _____ Sex: _____

SSN: _____ DOB: _____

Full Name: _____

Relationship: _____ Sex: _____

SSN: _____ DOB: _____

EMPLOYEE CERTIFICATION

I certify that any false statement or misrepresentation in this application may result in loss of coverage under the policy.

Employee Signature_____ Date: _____