

CHANGE REQUEST FORM

Important: Please print or type all sections in black ink.

Current Personal Information					
PacifiCare ID Number (if applicable)		Employer Name		Group Number (if applicable)	
Last Name		First Name		MI	Social Security #
Address (include apartment # if applicable)			City	State	ZIP
Home Telephone ()		Work Telephone ()		Work Telephone Extension	

Change of Personal Information	
<input type="checkbox"/> Change my address/phone as indicated above	<input type="checkbox"/> Change my name as shown above. My former name was:

Change of Dependent Status

Please check appropriate box and, **if an addition**, give reason

<input type="checkbox"/> Add <input type="checkbox"/> Del	Last Name	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship
Date of Birth (Month – Day – Year) – –	Effective Date of Coverage – –	PCP or Medical Group # (PacifiCare SignatureValue™ (HMO)/PacifiCare SignaturePOS™ (POS) only)		Reason <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Open enrollment <input type="checkbox"/> Other*
<input type="checkbox"/> Add <input type="checkbox"/> Del	Last Name	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Relationship
Date of Birth (Month – Day – Year) – –	Effective Date of Coverage – –	PCP or Medical Group # (PacifiCare SignatureValue™ (HMO)/PacifiCare SignaturePOS™ (POS) only)		Reason <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Open enrollment <input type="checkbox"/> Other*

* For "Other," please attach a letter of explanation.

Change of Eligibility

<input type="checkbox"/> Cancel all coverage	Effective Date _____	Reason _____
<input type="checkbox"/> Reinstatement	Effective Date _____	Reason _____
<input type="checkbox"/> COBRA (groups 20+)	<input type="checkbox"/> Continuing Coverage	Effective Date _____ Date benefits expire _____ Qualifying event _____
Members who will be continuing:		
Name	Relationship	
Name	Relationship	
Name	Relationship	

Change of Other Insurance Carrier Information

Add Delete

Last Name	First Name	MI	Date of Birth (Month – Day – Year) – –	Social Security #
Health Coverage Name	Policy # and Effective Date		Other Employee Name & Address	
Last Name	First Name	MI	Date of Birth (Month – Day – Year) – –	Social Security #
Health Coverage Name	Policy # and Effective Date		Other Employee Name & Address	

Change of Plan Type

- Plan changes can only be made during open enrollment.
- Before you change your plan, please confirm that your employer offers these plans.
- All family members must be in the same plan.
- If you are changing your plan type to a PacifiCare SignatureValueSM (HMO) or PacifiCare SignaturePOSSM (POS) plan from a PacifiCare SignatureOptionsSM (PPO) or PacifiCare SignatureIndependenceSM Plan, complete the section titled "PacifiCare SignatureValue (HMO)/PacifiCare SignaturePOS (POS) Members Only" below.

Change my plan:

From To

- PacifiCare SignatureValue (HMO)
 PacifiCare SignaturePOS (POS)
 PacifiCare SignatureOptions (PPO)[†]
 PacifiCare SignatureIndependence (Indemnity)[†]

[†] Underwritten by PacifiCare Life Assurance Company

PacifiCare SignatureValue (HMO)/PacifiCare SignaturePOS (POS) Members Only

Change of Primary Care Physician (PCP)/Medical Group

If you would like to change your PCP or Medical Group¹, you may do so once a month. The fastest and easiest way to do this is to call our Customer Service department. PacifiCare SignatureValue (HMO) members call 1-800-825-9355, PacifiCare SignaturePOS (POS) members call 1-800-837-3017. If you would prefer to do this in writing, please complete the section below.

PCP Selection (PacifiCare SignatureValue (HMO)/PacifiCare SignaturePOS (POS) Members only)

Complete this "PCP Selection" section if you are changing your plan type to a PacifiCare SignatureValue (HMO) or PacifiCare SignaturePOS (POS) plan from a PacifiCare SignatureOptions (PPO) or PacifiCare SignatureIndependence (Indemnity) plan, or if you are currently enrolled in a PacifiCare SignatureValue (HMO) or PacifiCare SignaturePOS (POS) plan and want to change your current PCP.

- Please select a doctor near your home for you and each of your family members from your PacifiCare SignatureValue (HMO) *Provider Directory* and write the name and number below.
- Please indicate your first and second choice.
- You may choose a different doctor for each member of your family.
- Did you select a doctor? If not, we will select one for you.

Eligible dependents are covered up to the age of 25. Disabled dependents 25 or older must provide proof of disability within 31 days of enrollment. (Limiting age up to 25 applies to TX only. For Oklahoma members, please consult your employer for specific age limitations.)

Dep. Code	Last Name	First	MI
Relationship			Sex <input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth		Social Security Number	
First Choice Primary Care Physician (PCP/OBGYN) or Medical Group Name			Existing Patient <input type="checkbox"/> Y <input type="checkbox"/> N
Number			
Second Choice Primary Care Physician (PCP/OBGYN) or Medical Group Name			Existing Patient <input type="checkbox"/> Y <input type="checkbox"/> N
Number			
Dep. Code	Last Name	First	MI
Relationship			Sex <input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth		Social Security Number	
First Choice Primary Care Physician (PCP/OBGYN) or Medical Group Name			Existing Patient <input type="checkbox"/> Y <input type="checkbox"/> N
Number			
Second Choice Primary Care Physician (PCP/OBGYN) or Medical Group Name			Existing Patient <input type="checkbox"/> Y <input type="checkbox"/> N
Number			

Change to Existing Life Insurance Coverage

Effective date of all changes	Indicate reason(s) for all changes		
<input type="checkbox"/> Terminate Employee Life Coverage <input type="checkbox"/> Add Dependent Life Coverage <input type="checkbox"/> Terminate Dependent Life Coverage			
Please change to: <input type="checkbox"/> New Name _____ <input type="checkbox"/> New Amount of Insurance \$ _____			
<input type="checkbox"/> Other changes (be specific) _____			
<input type="checkbox"/> New Beneficiary Information: Name _____ Birthdate _____			
Relationship _____			
I understand that if I am disabled and not able to be at work on the date life insurance (and dependent life insurance) is to become effective, coverage will not take effect until I return to active employment and meet all of the Policyholder's eligibility requirements. I represent to the best of my knowledge that the information is true and I hereby authorize payroll deductions from my earnings for any contributions or fees as may be required to maintain my eligibility.			
Your Signature		Date	
Employer Verification/Authorized Signature		Phone Number	Date

¹All medical group changes must be approved by PacifiCare before becoming effective. All ongoing medical care being received from referral providers must be discontinued by the effective date of your medical group change. Please have your condition evaluated by your new Primary Care Physician.

²OB/GYN selection applies to Texas members only.

Customer Service: 1-800-825-9355 (PacifiCare SignatureValue (HMO)); 1-800-837-3017 (PacifiCare SignaturePOS (POS)); 1-866-316-9776 (PacifiCare SignatureOptions (PPO))

PacifiCare Use Only

PAC Effective Date	Verified By	Date Verified
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