CCHP

170 Columbus Ave, Ste 210, San Francisco, CA 94133

FAX to Member Services (415) 397-2129

MEMBER/GROUP CHANGE FORM (Form B 1)

Please check(√) one of the following:

- ☐ **ADD dependent/spouse shown below**
- ☐ **DELETE employee/dependent/spouse shown below**
- ☐ **REINSTATE**
- ☐ **CHANGE**
- ☐ **TERMINATION OF GROUP CONTRACT**

Please indicate effective date of your request:

Effective Date: ______________________**(1st day of the effective month)**

Check (√) one of the below boxes if terminated employee elects the following coverage:

- ☐ **CALCOBRA (**Group with 2-19 employees**)**
- ☐ **COBRA (**Group with 20 and more employees**)**

Please check(√) appropriate reason for Add/Delete/Reinstate/Change/Termination:

- ☐**Marriage** (Attach marriage certificate)
- ☐ **Birth/Adoption** (Attach birth certificate/legal doc)
- ☐ **Name or Address Change** (Attach legal doc)
- ☐**Divorced** (Attach final divorce decree)
- ☐ **Employment termination/Reduction of hour**
- ☐ **Open Enrollment**
- ☐**Separation** (Attach legal document)
- ☐ **Ineligible dependent** (child reached max. age)
- ☐ **Change Benefit Plan**
- ☐ **Eligible for Medicare**
- ☐ **Other** ________________________________ **(**please indicate the reason**)**

Group Name ________________________________ Group # ________________ Phone ____________________

Employee Last Name ______________ First Name ______________ MI _____ SS# ____________ Member ID# ___________

Current Home Address ___________________________ City ________ Zip _________ Home Tel ____________ ☐ male ☐ female

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Please list only member(s) that require change

	Last Name First MI	Birth Date Mo Day Yr	Sex	Social Security No.	Selected Physician Name	CCHP use only
☐ Employee						
☐ Spouse						
☐ daughter ☐ son						
☐ daughter ☐ son						
☐ daughter ☐ son						

Name and Signature of person completing form: ____ Date: ______________

Employer Signature: ______________________Employee Signature: ____________________ Date: ______________

NT/ form/member change form/ revised 07/2006