



CCHP

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**FAX to Member Services
(415) 397-2129**

MEMBER/GROUP CHANGE FORM (Form B 1)

<p>Please check (✓) one of the following:</p> <p><input type="checkbox"/> ADD employee/dependent/spouse shown below</p> <p><input type="checkbox"/> DELETE employee/dependent/spouse shown below</p> <p><input type="checkbox"/> REINSTATE</p> <p><input type="checkbox"/> CHANGE name or address</p> <p><input type="checkbox"/> TERMINATION of Medical / Dental / Vision Contract</p>	<p>Please indicate effective date of your request:</p> <p>Effective Date: _____ (1st day of the effective month)</p> <p>Check (✓) one of the below boxes if terminated employee elects the following coverage:</p> <p><input type="checkbox"/> CALCOBRA (Group with 2-19 employees)</p> <p><input type="checkbox"/> COBRA (Group with 20 and more employees)</p>
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Please check(✓) appropriate reason for Add/Delete/Reinstate/Change/Termination:

<input type="checkbox"/> New Hire	<input type="checkbox"/> Marriage (Attach marriage certificate)	<input type="checkbox"/> Birth/Adoption (Attach birth certificate/legal doc)
<input type="checkbox"/> Divorced (Attach final divorce decree)	<input type="checkbox"/> Separation (Attach legal document)	<input type="checkbox"/> Ineligible Dependent (child reached max. age)
<input type="checkbox"/> Employment Termination/Reduction of Hour	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Eligible for Medicare
<input type="checkbox"/> Other _____		

Group Name _____ Group # _____ Phone _____

Employee Last Name _____ First Name _____ MI _____ SS# _____ Member ID# _____

Current Home Address _____ City _____ Zip _____ Home Tel _____ o

Male Female Medical Dental Vision

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
<input type="checkbox"/> Employee								
<input type="checkbox"/> Spouse								
<input type="checkbox"/> Daughter <input type="checkbox"/> Son								
<input type="checkbox"/> Daughter <input type="checkbox"/> Son								
<input type="checkbox"/> Daughter <input type="checkbox"/> Son								

*Note: Please also submit the employee enrollment form & DE6 or payroll stubs for proof of employment status.
All changes must be submitted at least **10 days prior** to the proposed effective date with your monthly payment and document that proof of eligibility.*

Employer Signature: _____ Employee Signature: _____ Date: _____