MercyCare Health Plans™

CHANGE OF STATUS FORM

Please Print

PHONE (800) 752-3431
FAX (608) 752-3751
EMAIL: mchpenrollment@mhemail.org

GROUP/EMPLOYER NAME				GROUP NUMBER	EFFECTIVE DATE OF CHANGE
SUBSCRIBER LAST NAME	FIRST	M.I.	SEX ☐ M ☐ F	SOCIAL SECURITY #	TODAY'S DATE
SUBSCRIBER ADDRESS	CITY	ZIP	CHECK IF NEW ☐	HOME PHONE	CHECK IF NEW ☐

☐ **ADDITION (S)** **OR** ☐ **DELETION (S)**

RELATIONSHIP	LAST NAME	FIRST	M.I.	SOCIAL SECURITY #	DATE OF BIRTH	SEX	PRIMARY CARE PHYSICIAN

PLEASE CHECK REASON FOR CHANGE:

☐ BIRTH OR ADOPTION
☐ MARRIAGE – DATE: _____
☐ DIVORCE
☐ ADDRESS CHANGE
☐ OTHER (please explain) _____
☐ COBRA/CONTINUATION ☐ 18 MONTH ☐ 36 MONTH
☐ EMPLOYEE DISENROLLED
☐ EMPLOYEE INELIGIBLE
☐ EMPLOYEE LAID OFF
☐ DEPENDENT OVER AGE
☐ LEFT EMPLOYMENT
☐ MOVED OUT-OF-AREA
☐ EMPLOYEE DECEASED
☐ DEPENDENT DECEASED
☐ COORDINATION OF BENEFITS CHANGE/OTHER INSURANCE (please explain) _____

NAME CHANGE

FROM: TO:

I hereby apply for amendment of my application. It is mutually agreed as follows: That these changes shall not become effective unless and until accepted; that this application for change in coverage will become part of my original application and will be subject to the terms of agreement(s) in effect with MercyCare Health Plans.

SIGNATURE OF SUBSCRIBER _____ SIGNATURE OF EMPLOYER (Required) _____ DATE _____