

# EMPLOYEE/DEPENDENT CHANGE REQUEST FORM ECHG/TMNT

**PacifiCare®**

(Cancel/Add/Change Coverage)

See instructions on back - Incomplete information can delay the enrollment process

If Applicable:

Department/Agency	Appropriation #
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## Section One

Subscriber's Last Name		First Name			Subscriber Social Security #			
Mailing Address				Apt #	City		State	ZIP
Home Phone		Business Phone			County			
Name of Person Completing Form If Different Than Subscriber: Last Name					First Name		MI	

## Section Two - Change(s) Desired

<input type="checkbox"/> <b>Cancel Medical Coverage</b> <i>Reason:</i> _____ <input type="checkbox"/> <b>Change Address</b> <input type="checkbox"/> <b>Change Primary Care Physician</b> (complete Section Three) <input type="checkbox"/> <b>Change Name</b> <i>From:</i> _____ <i>To:</i> _____	<input type="checkbox"/> <b>Add or</b> <input type="checkbox"/> <b>Remove Dependents</b> (list names in Section Three) <i>Give reason for adding or removing Dependents if not open enrollment:</i> _____ - <b>If Marriage or Divorce</b> , give date: ____/____/____ - <b>If child is being adopted</b> , give date of adoption: ____/____/____ (Please attach a copy of adoption papers or court order of guardianship)
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## Section Three - Family Members to be Added or Removed OR Primary Care Physician Changes

Please use the first box on each line to indicate the type of change being made: A=Add a Member, R=Remove a Member, C=Change the Member's Primary Care Physician, S= Add Dependent's Social Security #.

Type of Change	Name (Last, First, MI)	Dependent's Social Security #	Relationship to Subscriber	Sex	Student over 19	Disabled	Date of Birth MM-DD-YY	Age	Primary Care Physician (PCP) Full Name and Street Address	Current Patient of PCP?	PacifiCare HMO Dentist Full Name and Street Address
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> Y <input type="checkbox"/> N	
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> Y <input type="checkbox"/> N	
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				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N				<input type="checkbox"/> Y <input type="checkbox"/> N	

## Section Four - Medicare

If **anyone** to be covered is currently eligible for Medicare, the following information is required for Subscriber **and** Dependents.

**Submit a copy of your Medicare card(s) with this form.** (See instruction 3 on back of form)

**Subscriber:**  Employed  Retired  Part A  Part A&B  Part B Medicare Claim #: \_\_\_\_\_

**Spouse/Dependent:**  Employed  Retired  Part A  Part A&B  Part B Medicare Claim #: \_\_\_\_\_

*Note: If you are enrolling in a Medicare Supplement Plan through your employer, check with your employer for the additional forms required.*

## Section Five

**I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR DISPUTES OVER BENEFIT DENIALS SUBJECT TO ERISA, BETWEEN ITSELF, MEMBERS (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF COLORADO, INC., OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION. RIGHTS AFFORDED UNDER THE INTERNAL APPEALS PROCESS AND INDEPENDENT EXTERNAL REVIEW ARE NOT AFFECTED BY THIS PROVISION. DISPUTES NOT FULLY RESOLVED THROUGH THE INDEPENDENT EXTERNAL REVIEW PROCESS ARE SUBJECT TO THIS PROVISION.**

Signature of Subscriber	Date (MM/DD/YY)	Date Employment Terminated
Employer Name (If Applicable)	Group # (if applicable)	Effective Date of Change (mm/dd/yy)

## For PacifiCare Use Only

Group #	Tier	Effective Date (MM-DD-YYYY)
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## Instructions

1. Complete all the information requested.
2. If each covered member of your family does not have a Primary Care Physician, please select one and indicate your choice on this form. If desired, each family member may have a different Primary Care Physician. Participating Primary Care Physicians are listed in the *PacifiCare Provider Directory*.
3. If any covered member of your family has become eligible to receive benefits under Medicare, the Medicare box must be completed. Supply the information for the subscriber whether or not he/she is Medicare Eligible (if not Medicare eligible, omit Medicare Claim No.). Also supply the information for a Spouse or Dependent to be covered who is Medicare Eligible. Check "Employed" if the person is still working or "Retired" if the person is no longer working. If the person has both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) or only Part A or Part B, also check that regardless of whether the person is employed or retired. **Submit a copy of your Medicare card(s) with this change card if you have not done so previously.**
4. Sign and date this form. Make a copy of this form for your records.
5. Return this form to your employer's benefits office if you are enrolled in a group plan through the employer. Send this form to PacifiCare if you have nongroup Individual or Conversion Plan coverage.
6. If an employee has terminated employment and is not available, the employer may complete this form to cancel coverage. It is the employer's responsibility to notify terminated employees of the availability of continuation of coverage.

## Remember

Notify your employer promptly of any change in the status of your family that affects your coverage.

You can call PacifiCare Customer Service Department if your address changes or if you wish to change your Primary Care Physician. Primary Care Physician changes will become effective on the first day of the following month.

If you or any covered member of your family becomes ineligible to continue coverage under this plan, notify your employer promptly if interested in maintaining continuous coverage.

Important information on how to use PacifiCare can be found in your *Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage and Owner's Manual* or on your PacifiCare identification card.

NOTE: Send changes to group information (e.g. address, phone number) in writing to your Account Manager or the address below.

### Customer Service:

■ **SignatureValue<sup>SM</sup> (HMO) and SignaturePOS<sup>SM</sup>**  
1-800-877-9777  
TDHI 1-800-360-1797

■ **SignatureOptions<sup>SM</sup> (PPO) and SignatureIndependence<sup>SM</sup> (Indemnity)**  
1-866-316-9776  
TDHI 1-866-816-2018

■ **SignatureFreedom<sup>SM</sup> (SDHP)**  
1-866-867-0700  
TDHI 1-866-867-0701

[www.pacificare.com](http://www.pacificare.com)

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