



Community Health Plan  
 Heartland Health Business Plaza  
 137 N. Belt Hwy.  
 St. Joseph, MO 64506  
 (816) 271-1247 or (800) 990-9247 - telephone  
 (816) 271-7976 - fax  
**Complete and return to Community Health Plan. Please print firmly.**

# Change Form

Use this form to indicate changes in member coverage information.

**EFFECTIVE DATE OF CHANGE:** \_\_\_\_\_

<b>EMPLOYEE NAME (Last, Middle, First):</b>	<b>MEMBER ID NUMBER:</b>	<b>EMPLOYER NAME:</b>
<input type="checkbox"/> <b>CHANGE MEMBER INFORMATION:</b>  <input type="checkbox"/> NAME CHANGE Previous name: _____  <input type="checkbox"/> ADDRESS CHANGE (Street, City, State, Zip) New address: _____  <input type="checkbox"/> TELEPHONE NUMBER CHANGE New phone: _____	<input type="checkbox"/> <b>ELIGIBILITY CHANGE:</b> <b>Please Check Appropriate Box:</b> <b>STATE CONTINUATION OF COVERAGE</b> (Employee must be on current employer's group health plan for three (3) continuous months.) <input type="checkbox"/> <b>ELECTED</b> <input type="checkbox"/> <b>DECLINED</b> Reason: <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Death	
<input type="checkbox"/> <b>CHANGE PRIMARY CARE PROVIDER FOR:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Entire Family  <b>Provider Name:</b> _____	<b>COBRA (for groups of 20 or more employees)</b> <input type="checkbox"/> <b>ELECTED</b> <input type="checkbox"/> <b>DECLINED</b> Reason: <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Reduction in Work Hours <input type="checkbox"/> Loss of Dependent Eligibility <input type="checkbox"/> Retirement <input type="checkbox"/> Medicare Eligibility <input type="checkbox"/> Death	
<input type="checkbox"/> <b>CHANGE PLAN TO:</b> <input type="checkbox"/> Community Gold <input type="checkbox"/> Community Choice <input type="checkbox"/> Point of Service <input type="checkbox"/> Select Choice PPO <input type="checkbox"/> Quality Choice PPO		
<input type="checkbox"/> <b>CANCEL COVERAGE FOR:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Entire Family <input type="checkbox"/> <b>CANCEL COVERAGE TYPE:</b> <input type="checkbox"/> Health Only <input type="checkbox"/> Life Only <input type="checkbox"/> All Coverage		
Employee (Subscriber) Signature	Date	Employee Signature
		Date

**Instructions for Completing Change Form:**

1. **Effective Date of Change** – Date should be the day the change (termination, divorce, reduction in hours, loss of dependent eligibility, retirement, Medicare eligibility or death) occurs.
2. **Employee Name** – Name of employee (subscriber) as it appears on the plan ID card.
3. **Member ID Number** – The ID number of the employee (subscriber) as it appears on the plan ID card.
4. **Employer Name** – Name of Group as contracted with Community Health Plan.
5. **Change Member Information** – Check applicable box/es for Name Change, Address Change or Telephone Number change.
6. **Eligibility Change** – Missouri Continuation or COBRA selection and, if elected, the reason for the eligibility change. In case of death of the subscriber, the election of COBRA is by spouse and/or dependents
7. **Change Primary Care Provider for** – If the change is to one primary care provider for all family members including the employee (subscriber), check “Entire Family” and write in Provider Name. If more than one provider is requested, please use separate piece of paper and list each member’s name and the requested provider.
8. **Change Plan to** – If your employer offers more than one level of coverage, check the coverage you wish to change to.
9. **Cancel Coverage for** – Please check box/es to the right if this change is for self, spouse, or eligible dependents. If coverage is being cancelled for the entire family, including the employee (subscriber), then check “Entire Family”.
10. **Cancel Coverage Type** – If the member is dropping only health coverage, please check “Health Only”. For companies that furnish Life Insurance, this coverage must continue as long as the employee meets the full-time hours requirement as stated in your Group Application.
11. **Member Signature** – (required for all changes except termination)
12. **Employer Signature** – (required for all changes)