



CHANGE FORM

(Member changes must be received by Priority Health within 31 days of the event.)

Alternate Benefits of fully-funded Point-of-Service Plan underwritten by Allianz Life Insurance Company of North America

SECTION 1 - EMPLOYEE INFORMATION

Employee's Last Name	First Name	Middle Initial	Social Security Number ____ - ____ - ____
Employer/Company Name			

SECTION 2 - CHANGES

Please complete only those changes which apply.

<input type="checkbox"/> ADDRESS/PHONE CHANGE		Street Address	City	
State	Zip Code	County	Home Phone () - () - ()	Work Phone () - () - ()
<input type="checkbox"/> NAME CHANGE		New Last Name	Former Last Name	

<input type="checkbox"/> DEPENDENT CHANGE (If you have more than 4 dependent changes please complete an additional change form).				Date Change Occurred / /	Reason for Change Add <input type="checkbox"/> Delete <input type="checkbox"/>	
1	Last Name		First Name		Middle Initial	Social Security Number ____ - ____ - ____
	Birth Date / /	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Relation to Employee		Priority Health Primary Care Provider (PCP)	
	Has this dependent ever seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/Location			
2	Last Name		First Name		Middle Initial	Social Security Number ____ - ____ - ____
	Birth Date / /	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Relation to Employee		Priority Health Primary Care Provider (PCP)	
	Has this dependent ever seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/Location			
3	Last Name		First Name		Middle Initial	Social Security Number ____ - ____ - ____
	Birth Date / /	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Relation to Employee		Priority Health Primary Care Provider (PCP)	
	Has this dependent ever seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/Location			
4	Last Name		First Name		Middle Initial	Social Security Number ____ - ____ - ____
	Birth Date / /	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Relation to Employee		Priority Health Primary Care Provider (PCP)	
	Has this dependent ever seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/Location			

If you, or your spouse, or any dependents are covered by Medicare or any other insurance policy providing medical benefits, please complete this section.

WHERE ARE CLAIMS SENT?	Company Name	Company Address			
POLICYHOLDER INFORMATION	Name of Policyholder	Birthdate / /	Policy Effective Date / /	Employer	
	Family Member(s) Covered (1) (2) (3) (4)				
REASON FOR MEDICARE	End Stage Renal Disease <input type="checkbox"/>	Disabled <input type="checkbox"/>	Over Age 65 <input type="checkbox"/>	Over Age 65 and Working <input type="checkbox"/>	Effective Date / /

SECTION 3 - AUTHORIZATION

I authorize Priority Health to make the changes indicated above for me and my dependents. I understand that Priority Health may request pertinent sworn statements if needed and that I must sign and date this form before it will be processed.

X _____
Employee Signature Date

For Employer Use Only	Employer/Company Name	Group Number	Site Change	Effective Date / /
	Employer/Company Representative Signature			Date / /
	REASONS FOR ADDITIONS Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Lost Eligibility <input type="checkbox"/> Other _____			Date Coverage Began / /
	REASONS FOR DELETIONS Marriage of Dependent <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Lost Eligibility <input type="checkbox"/> Other <input type="checkbox"/> _____			Date Coverage Ended / /
	REASON FOR TERMINATION OF ENTIRE CONTRACT Terminated Employment <input type="checkbox"/> Lay Off <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Changed Health Plans <input type="checkbox"/> Moved out of area <input type="checkbox"/> Deceased <input type="checkbox"/> COBRA Terminated <input type="checkbox"/> Dissatisfied <input type="checkbox"/> Other <input type="checkbox"/> _____			Date Occurred / / Date Coverage Ended / /

For Priority Health Use Only	Date Received / /	Contract Number	Processor	Code	Date Processed / /
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PRIMARY CARE PROVIDER CHANGE FORM

(Please complete this form to change your Primary Care Provider.)

If you would like assistance with your change,
please call our Helpline at 800 446-5674

SECTION 1 - EMPLOYEE INFORMATION

Employee's Last Name	First Name	Middle Initial	Social Security Number — — —
Employer/Company Name			Group Number

SECTION 2 - PRIMARY CARE PROVIDER

This change becomes effective the first of the month following the date your form is received by Priority Health.

Employee/Dependent Name	Priority Health Primary Care Provider (PCP)	PCP Address/Location	Have you or this dependent ever seen this provider?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

REASON FOR CHANGE	<input type="checkbox"/> Member moved	<input type="checkbox"/> Communication problems with PCP/office staff
	<input type="checkbox"/> PCP moved	<input type="checkbox"/> Hard time getting appointments
	<input type="checkbox"/> PCP left practice	<input type="checkbox"/> Wait time in the office too long
	<input type="checkbox"/> Office location is hard to get to	<input type="checkbox"/> Not satisfied with office staff
	<input type="checkbox"/> PCP No Longer with Priority Health	<input type="checkbox"/> PCP/office staff rude or uncaring
	<input type="checkbox"/> Did not want PCP Priority Health assigned	<input type="checkbox"/> Poor quality of medical care
	<input type="checkbox"/> Personal Preference	

SECTION 3 - AUTHORIZATION FOR PRIMARY CARE PROVIDER CHANGE

I authorize Priority Health to make the changes indicated above for me and my dependents. I understand that I must sign and date this form before it will be processed.

X _____
Employee Signature Date

For Priority Health Use Only	Date Received	Contract Number	Processor	Code	Date Processed
	Effective Date			ID Card Sent	

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