Pacific Health Advantage
Choice • Simplicity • Affordability

INDIVIDUAL ASSOCIATION MEMBER OPEN ENROLLMENT CHANGE FORM

Please complete this form and return to your association/agent. Use black or blue ink. For optimum accuracy, please print in capital letters and avoid contact with the edge of the box. When you see a choice of one or more boxes, please put an X in the one that most accurately applies.

COMPLETE THIS FORM ONLY IF MAKING CHANGES TO YOUR COVERAGE, OR GENERAL INFORMATION.

REQUIRED INFORMATION (IF MAKING CHANGES)

ASSOCIATION MEMBER NUMBER

SOCIAL SECURITY NUMBER - -

MEMBER LAST NAME

MEMBER FIRST NAME

M. I.

BIRTH DATE / /

COMPLETE ONLY THOSE FIELDS BELOW WHICH CORRESPOND TO THE INFORMATION YOU WISH TO CHANGE.

MARITAL STATUS

☐ SINGLE ☐ MARRIED

HOW WOULD YOU LIKE TO RECEIVE CORRESPONDENCE FROM THE PROGRAM?

☐ US MAIL ☐ FAX ☐ E-MAIL

E-MAIL ADDRESS (IF APPLICABLE)

HOME ADDRESS

APARTMENT

CITY

STATE

ZIP CODE -

MAILING ADDRESS

SUITE / APARTMENT

CITY

STATE

ZIP CODE -

HOME PHONE NUMBER ( ) -

FAX NUMBER ( ) -

34100

Revised 04/05/99

INDIVIDUAL ASSOCIATION MEMBER OPEN ENROLLMENT CHANGE FORM

SOCIAL SECURITY NUMBER

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

HEALTH PLAN SELECTION

PLAN NUMBER

[ ][ ][ ]

INDICATE YOUR SELECTED PARTICIPATING HEALTH PLAN NAME

[ ]

INDICATE COVERAGE CHOICE

- ☐ MEMBER ONLY
- ☐ MEMBER AND CHILD(REN)
- ☐ MEMBER AND SPOUSE
- ☐ FAMILY

INDICATE YOUR HMO OPTION

- ☐ PREFERRED
- ☐ PLUS
- ☐ STANDARD

INDICATE YOUR PRIMARY CARE PHYSICIAN / MEDICAL GROUP ID NUMBER

[ ][ ][ ][ ][ ][ ][ ][ ][ ]

ARE YOU AN EXISTING PATIENT?

☐ YES ☐ NO

INDICATE YOUR PRIMARY CARE PHYSICIAN'S LAST NAME

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

INDICATE YOUR PRIMARY CARE PHYSICIAN'S FIRST NAME

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

DENTAL PLAN SELECTION (IF APPLICABLE)

PLAN NUMBER

[ ][ ][ ]

INDICATE YOUR SELECTED PARTICIPATING DENTAL PLAN NAME

[ ]

INDICATE COVERAGE CHOICE

- ☐ MEMBER ONLY
- ☐ MEMBER AND CHILD(REN)
- ☐ MEMBER AND SPOUSE
- ☐ FAMILY

INDICATE YOUR DENTIST / DENTAL GROUP ID NUMBER

[ ][ ][ ][ ][ ][ ][ ][ ][ ]

ARE YOU AN EXISTING PATIENT?

☐ YES ☐ NO

INDICATE YOUR DENTIST'S LAST NAME

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

INDICATE YOUR DENTIST'S FIRST NAME

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

VISION PLAN SELECTION (IF APPLICABLE)

PLAN NUMBER

[ ][ ][ ]

INDICATE YOUR SELECTED PARTICIPATING VISION PLAN NAME

[ ]

INDICATE COVERAGE CHOICE

☐ MEMBER ONLY ☐ MEMBER AND SPOUSE ☐ MEMBER AND CHILD(REN) ☐ FAMILY

INDICATE YOUR VISION OPTION

☐ PREFERRED ☐ PLUS

SIGNATURES

SIGNATURE OF MEMBER (REQUIRED)

DATE SIGNED

[ ][ ] / [ ][ ] / [ ][ ][ ][ ]