

Individual Plan



CHANGE REQUEST FORM

SUBSCRIBER INFORMATION.

IMPORTANT: PLEASE PRINT OR TYPE ALL SECTIONS IN BLACK INK.

PacifiCare ID Number			Current Plan Type (Please Check One)		
			<input type="checkbox"/> HMO		<input type="checkbox"/> POS
Last Name	First	MI	Social Security Number		
Address		Apt No.	City	State	Zip Code
Home Telephone		Work Telephone		Extension	
()		()			

CHANGE AS INDICATED BELOW:

- Change my home address/phone as indicated above.
- Change my billing address as indicated above.
- Change my name as shown above. My former name was _____

CHANGE OF DEPENDENT STATUS

If you wish to add a dependent other than a newborn or adopted child, please contact your broker or PacifiCare at 1-800-577-0001 for an enrollment application and health questionnaire. To add a newborn or adopted child, or to delete a dependent from your current coverage, please check the appropriate box and provide the requested information.

Add or Delete	Relationship	Last Name	Date of Birth (Month - Day - Year)	Effective Date of Coverage
	Sex M or F	First Name	MI	PCP or Medical Group Number
Add or Delete	Relationship	Last Name	Date of Birth (Month - Day - Year)	Effective Date of Coverage
	Sex M or F	First Name	MI	PCP or Medical Group Number

CHANGE OF PCP/MEDICAL GROUP

■ Changes received by the 15th of the month will become effective the 1st of the following month. Changes received after the 15th of the month will be effective for the 1st day of the subsequent month. FOR EXAMPLE: If notification is received January 14th, the change would be effective February 1. If the change was received January 20th, the change would be effective March 1. Some restrictions apply. Please call PacifiCare Member Services Department with any questions.

■ ALL MEDICAL GROUP TRANSFERS MUST BE APPROVED BY PACIFICARE BEFORE BECOMING EFFECTIVE. All ongoing medical care being received from referral providers must be discontinued by the effective date of your medical group change. Your condition must be re-evaluated by your new Primary Care Physician.

1	Self	Last Name	Social Security Number	Primary Care Physician Name	PCP # - OR - Group #	Primary Care Physician (PCP) Number	Existing Patient?
	Sex M or F	First Name	MI	Date of Birth (Month - Day - Year)	Medical Group Name	Medical Group Number	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Spouse	Last Name	Social Security Number	Primary Care Physician Name	PCP # - OR - Group #	Primary Care Physician (PCP) Number	Existing Patient?
	Sex M or F	First Name	MI	Date of Birth (Month - Day - Year)	Medical Group Name	Medical Group Number	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP # - OR - Group #	Primary Care Physician (PCP) Number	Existing Patient?
	Sex M or F	First Name	MI	Date of Birth (Month - Day - Year)	Medical Group Name	Medical Group Number	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP # - OR - Group #	Primary Care Physician (PCP) Number	Existing Patient?
	Sex M or F	First Name	MI	Date of Birth (Month - Day - Year)	Medical Group Name	Medical Group Number	<input type="checkbox"/> Yes <input type="checkbox"/> No

Your Signature _____

Date _____

Questions? Call Individual HMO at 1-800-207-2077
Call Individual POS at 1-800-913-9133

Please mail to: **INDIVIDUAL PLANS**
Subscriber Receivables
5701 Katella Avenue
Mail Stop # CY24-597
Cypress, CA 90630-5019
Fax # (714) 226-5168

PACIFICARE USE ONLY

PAC EFFECTIVE DATE	VERIFIED BY	DATE VERIFIED