QualChoice HEALTH INSURANCE

Change Form

Use this form to add or change a member's eligibility status or change other data. The form **must** be signed by the Group Administrator. For terminations, please use the Termination Form.

Reason for Change. *Check all that apply.*
Adding Dependent(s) - Section II. *Employee signature required.* ☐ COBRA Election - Section II
☐ Address Change – Section III ☐ Name Change – Section IV

Section I. Employee Identification

Employee Name *(Last, First, MI)*	QualChoice ID No. or SSN	Group/Plan Sponsor Name	Group ID No. (from ID Card)

Section II. Adding Dependent(s)

Fill out this section to add a spouse or dependent child to your coverage. Request must be due to a qualifying event as stated in your Evidence of Coverage (EOC). The employee must fill out and sign this section and any attachments. You may copy and attach extra pages as needed if adding multiple dependent children.

Please attach supporting papers. Such as a marriage certificate, proof of loss of other coverage, etc.

IMPORTANT: By signing below, you certify that each "Child" listed is: (1) either your son, daughter, stepson, stepdaughter, an individual legally adopted by you, or an individual lawfully placed with you for legal adoption (a foster child is not eligible to be enrolled as your "Child"), or an individual for whom you are the legal guardian; (2) under the age of 26; and (3) not eligible to enroll in another employer-sponsored health insurance plan (if your group health plan is considered a 'grandfathered' plan under the Affordable Care Act).

Type of Qualifying Event

☐ Birth ☐ Marriage ☐ Retiree ☐ COBRA (see your Group Administrator for forms to complete and submit)
☐ Loss of Other Coverage: Last Date of Coverage: _____ (MM/DD/YYYY) Carrier Name _____
☐ Other: _____

Coverage Requested:

☐ Medical ☐ Vision ☐ Dental ☐ Life/AD&D (If electing Life/AD&D insured must complete *Group Life Insurance Health Statement* before coverage will be approved. Form available at qualchoice.com.)

Dependent Name *(Last, First, MI)*	Relationship	Gender	Social Security No.	Date of Birth (MM/DD/YYYY)
	☐ Spouse ☐ Dependent child	☐ Male ☐ Female		

Type of Qualifying Event

☐ Birth ☐ Marriage ☐ Retiree ☐ COBRA (see your Group Administrator for forms to complete and submit)
☐ Loss of Other Coverage: Last Date of Coverage: _____ (MM/DD/YYYY) Carrier Name _____
☐ Other: _____

Coverage Requested:

☐ Medical ☐ Vision ☐ Dental ☐ Life/AD&D (If electing Life/AD&D insured must complete *Group Life Insurance Health Statement* before coverage will be approved. Form available at qualchoice.com.)

Dependent Name *(Last, First, MI)*	Relationship	Gender	Social Security No.	Date of Birth (MM/DD/YYYY)
	☐ Spouse ☐ Dependent child	☐ Male ☐ Female		

Employee Signature Required

In signing below: (1) I represent that the statements and answers given (or any attachment) are true, complete and correctly recorded to the best of my knowledge and belief; (2) I authorize any doctor, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company having Protected Health Information (PHI) with respect to any physical or mental condition or treatment on me or any member of my family (if applicable), to give QualChoice, its respective agents, affiliates, reinsurers, appropriate reporting agencies or legal representatives any and all such information to use for underwriting or claims purposes; (3) I understand that QualChoice may deny coverage if authorization is not given to obtain any additional PHI; (4) I understand that if QualChoice approves coverage, the PHI received will become a part of my record with QualChoice and, further, if QualChoice denies coverage, QualChoice will not use, disclose or retain the PHI except as required or authorized by law; (5) I agree that a copy of this authorization shall be as valid as the original. I understand that a copy is available to me upon request. I understand that any fraudulent statement, omission, or material misrepresentation may result in QualChoice terminating or rescinding (voiding) any coverage, including dependent coverage, issued in reliance thereon, and that QualChoice may recover any money and damages incidental and consequential that result.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false Information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Print Employee Name	Employee Signature **(Required)**	Date (MM/DD/YYYY)
	X	

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Section III. Address Change			
QualChoice ID No. or SSN	Member Name *(Last, First, MI)*		Effective Date (MM/DD/YYYY)
New Street Address	City	State	Zip

Section IV. Name Change		
QualChoice ID No. or SSN	Former Name *(Last, First, MI)*	Effective Date (MM/DD/YYYY)
Name Changed to		
Reason for Change		

Section V. Signature Of Group Administrator		
In signing below, I represent that the statements on this form (or any attachment hereto) are true, complete and correctly recorded to the best of my knowledge and belief.		
Print Group Administrator Name	Group Administrator Signature **(Required)** **X**	Date (MM/DD/YYYY)

Section VI. Instructions		
Mail	**Fax**	**Email**
QualChoice ATTN: Enrollment P.O. Box 25610 Little Rock, AR 72221	501.707.6805	QCA_Enrollment@qualchoice.com

Be sure to keep a copy of this document for your files.