Group number: _____

Telemedicine Change Form

Instructions: Please complete boxes outlined in **RED**

A: Personal Information

Last Name: Middle Initial: First Name:
Date of Birth: __/__/____ Social Security Number:
Street Address: Apt #:
City: State: Zip Code:
Home Phone Number: E-mail Address:
Marital Status: Single Married Divorced Widowed
Gender: Male Female Tobacco Usage: Yes No

B: Type of Change [MUST SELECT OPTION(S) AND FILL IN INFORMATION]

☐ **Name Change:**
Previous Name:
New Name:

☐ **Address Change:**
Previous Address:

New Address:

☐ **Cancel Current Medical Coverage***
Cancellation Date: _____/_____/_____
*Subjected to contracted date - coverage may extend to last day of month.

C: Qualifying Event Information*

Qualifying Event:

_____

_____

_____

Date of Qualifying Event: _____/_____/_____
*Proof of qualifying event may be requested.

D: Acknowledgement of Coverage and Signature

Name Printed:

Signature: Signature Date: _____/_____/_____