



Change of Status for Individual Coverage

Primary Member Information

First Name _____ Middle Name _____ Last Name _____

Date of Birth (MM/DD/YYYY) _____ SSN or Member ID Number _____

Daytime Phone _____

Member or Dependent(s) Cancellation – List all Members Being Cancelled

First Name

Last Name

First Name	Last Name

Effective Date of Cancellation _____

Member or Dependent(s) Addition

First Name _____ Last Name _____ DOB (MM/DD/YYYY) _____

Gender Male Female SSN _____

Relationship to Member Spouse/Domestic Partner Dependent Child

Tobacco User Yes No

What is the qualifying event for this addition?

Marriage/Divorce Birth/Adoption Change in Income

Changes to Citizenship Changes to Citizenship or Immigration Status

Release from Incarceration Return from Military Service

Loss of Other Coverage (e.g. employer coverage, Medicaid or CHIP, COBRA expiration)

Relocation to a New Zip Code, County, or State

Effective Date of the Above Change _____

Name Change

Old Name _____ New Name _____



Address/Phone/Email Change

New Mailing Address (Street or PO Box, City, State, Zip)

New Billing Address (If Different from Mailing)

New Email Address (New Email Address Required if Primary Member is Being Cancelled/Removed from Policy)

New Phone Number

Billing Change (Select All That Apply)

- Billing Address Change (Complete Billing Address Change on Page 1)
- Electronic Billing to Paper Billing (Complete Billing Address Change on Page 1)

Authorization Signature of Change

I authorize MHC to make the changes to my policy as indicated above. The effective date for the changes or cancellation of family members will be assigned by MHC.

Signature of Member _____

Signature of Guardian (If Under 18 Years of Age) _____

Submit this completed form by uploading it through the Member Portal at <https://mountainhealthcoop.vbagateway.com/> or mail it to Mountain Health Co-Op, PO Box 5358, Helena, MT 59604.