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

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/, fax it to 406-447-5799, or mail it to Mountain Health Co-Op, PO Box 5358, Helena, MT 59604.