CoventryOne.

Underwritten by Coventry Health Care of Georgia, Inc.

Change Request Form

Important: Please print clearly in BLACK ink. Refer to your contract for eligibility requirements. Please keep a copy of this form for your records.

Check all that apply (up to three (3) changes are permitted per form):

Submit your completed Change Request Form to:

E-mail: cvtybillingandenrollment@healthplan.com
FAX: 877-899-6447
Address: Coventry*One* Member Services, P.O. Box 31210, Tampa, FL, 33631-3210

o Contact Information / Name Change o Newborn Addition o Remove / Move Dependents o Decrease Benefits / Cancel Coverage o Other

Primary Member Information This section is required for all requested changes and must reflect the information on your ID card.

Last name	First name	MI	Member ID number	Primary phone ( ) -

Address / Name Change Complete this section for changes in name, phone number, E-Mail, home address or mailing address.

Member name change (indicate both previous and new name)	New phone number	New E-mail address

New home address (Street, City, State, ZIP)	New mailing address (Street, City, State, ZIP)

Newborn Addition Complete this section to add a newborn or newly adopted child to your coverage. Requests must be received within 31 days (60 days in Iowa) of the date of birth or a new Application must be submitted and will be subject to medical underwriting.

Last name	First name	MI	Gender M F	Birthdate (mm/dd/yyyy)	Social Security Number

Remove / Move Dependents Complete this section for changes to current dependents.

Full name (Last, First, MI)	Social Security Number	Birthdate (mm/dd/yyyy)	Change requested (select ONE only)	Requested Effective Date of Change (mm/dd/yyyy)
			o Move to own policy o Move to a new policy with other dependents o Remove from policy; discontinue coverage	
			o Move to own policy o Move to a new policy with other dependents o Remove from policy; discontinue coverage	
			o Move to own policy o Move to a new policy with other dependents o Remove from policy; discontinue coverage	

Decrease Benefits or Cancel Coverage A request for a reduction in benefits or cancellation of coverage must be submitted by the end of the month prior to the requested effective date of change. Retroactive benefit reductions and terminations are not permitted. Benefit plan changes affect all covered members. Decreasing your benefits does not change your renewal date, at which time your rates will be recalculated.

o Decrease my benefits. Requested Effective Date _____ Change plan to: _____	o Cancel my coverage. Requested date of cancellation _____ Reason for cancellation: _____

Other Explain other requested changes in the space below. Note that certain changes require submission of a new Application for Health Coverage. These changes include addition of a spouse, an increase in benefit level and addition of a new dependent after 31 days of birth or adoption. Changes to banking information should be submitted on a new Banking Information Form.

Any person who knowingly or willfully presents a false or fraudulent statement or representation of any material fact or thing in the filing of a claim for payment of a loss or benefit or knowingly presents false information in an application for insurance commits the crime of insurance fraud, which is a felony, and will be punished by imprisonment, or by fine, or both.

Primary Applicant's Signature	Date	Spouse's Signature	Date
Dependent Applicant Signature**	Date	Dependent Applicant Signature**	Date

**Required age 18 and over.

PLEASE KEEP A COPY FOR YOUR RECORDS