



Change Form

A. CURRENT INFORMATION

Name _____ Subscriber ID# _____ Date of Birth _____
 Street Address _____ Unit# _____
 City _____ State _____ ZIP _____ Ph# (____) _____
 Current Plan HIPUtah Federal-HIPUtah
 Current Deductible \$500 \$1,000 \$2,500 \$5,000

B. CHANGES (COMPLETE CHANGES THAT APPLY)

- Name Change**
 From _____
 To _____
- Address Change**
 New Address _____ Unit# _____
 City _____ State _____ ZIP _____ Ph# (____) _____
- Deductible Change**
 \$500 \$1,000 \$2,500 \$5,000
Subscribers are only allowed to change to a higher deductible upon renewal. FOR JANUARY RENEWALS - Subscribers are allowed to switch to a higher deductible. **FOR JULY RENEWALS** - Subscribers can only switch to a higher deductible if there is a rate increase.
- Add Newborn/Adopted Child**
 Newborns and adopted children will only have coverage for 30 days from their date of birth, adoption, or placement. Additions must be submitted within 30 days of the date of birth, adoption, or placement. To extend coverage beyond the first 30 days, your newborn, adopted child, or child placed for adoption must apply for coverage with HIPUtah or Federal-HIPUtah separately and meet HIPUtah's or Federal-HIPUtah's Eligibility Requirements.

LAST NAME	FIRST NAME	INITIAL	SEX M/F	RELATIONSHIP	DATE OF BIRTH MM/DD/YY
				<input type="checkbox"/> NATURAL <input type="checkbox"/> ADOPTED*	
				<input type="checkbox"/> NATURAL <input type="checkbox"/> ADOPTED*	

*SUBMIT A COPY OF PLACEMENT OR ADOPTION PAPERS

NOTE: Changes to your plan must be received within 30 days of the renewal date (January 1 or July 1).

C. DISCONTINUANCE OF MEDICAL BENEFITS

- I hereby request the discontinuance of medical benefits received under contract by HIPUtah or Federal-HIPUtah. I understand that the discontinuance will be effective on the last day of the month following receipt and approval of this request by HIPUtah or Federal-HIPUtah. Once coverage is discontinued, I understand that I may have to wait 6 to 12 months from the termination date before I can reapply with a new application. Furthermore, I understand that **no cancellation will be made on a retroactive basis.**

Desired Term Date _____

D. SIGNATURE

By signing, you agree to the changes requested above. To terminate coverage, please mark the box in section "C." above before signing.

Subscriber Signature _____ Date _____