



CHANGE FORM

Employer:	Group #:	Member #:
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E M P L O Y E	Last Name:	First Name:	MI:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Social Security Number:	Date of Birth: (MM/DD/YYYY)	Primary Care Physician (PCP):	

Please check qualifying event and fill in the appropriate spouse and/or children information below.

<input type="checkbox"/> Marriage	<input type="checkbox"/> Left Employment	<input type="checkbox"/> Physician Change	Event Date
<input type="checkbox"/> Divorce	<input type="checkbox"/> Disability	<input type="checkbox"/> Name/Address/Phone Change	Effective Date
<input type="checkbox"/> Birth	<input type="checkbox"/> Retirement	<input type="checkbox"/> Cancel Coverage	
<input type="checkbox"/> Adoption	<input type="checkbox"/> COBRA	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Death	<input type="checkbox"/> Medicare Eligible	_____	

Address Change	Street Address: _____ City: _____ State: _____ Zip Code: _____
Name Change	Last Name: _____ First Name: _____ MI: _____
Phone Change	Day: _____ Evening: _____

S P O U S E	Last Name:	First Name:	MI:	Date of Birth: (MM/DD/YYYY)
	Social Security Number:	Primary Care Physician (PCP):		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female

Please attach a Certification of Dependency Form if the dependent children are not the biological children of either the applicant, spouse, or both.

C H I L D	Last Name:	First Name:	MI:	Date of Birth: (MM/DD/YYYY)
	Social Security Number:	Primary Care Physician (PCP):		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Handicapped ? <input type="checkbox"/> Yes <input type="checkbox"/> No (Attach handicapped dependent certification)		College Student? <input type="checkbox"/> Yes <input type="checkbox"/> No (Attach Proof from College)	

C H I L D	Last Name:	First Name:	MI:	Date of Birth: (MM/DD/YYYY)
	Social Security Number:	Primary Care Physician (PCP):		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Handicapped ? <input type="checkbox"/> Yes <input type="checkbox"/> No (Attach handicapped dependent certification)		College Student? <input type="checkbox"/> Yes <input type="checkbox"/> No (Attach Proof from College)	

C H I L D	Last Name:	First Name:	MI:	Date of Birth: (MM/DD/YYYY)
	Social Security Number:	Primary Care Physician (PCP):		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Handicapped ? <input type="checkbox"/> Yes <input type="checkbox"/> No (Attach handicapped dependent certification)		College Student? <input type="checkbox"/> Yes <input type="checkbox"/> No (Attach Proof from College)	

The Employer/Member hereby authorizes the above requested change(s) and agrees that the effective date of change(s) will be governed by the stipulations of the contract. I am aware that a change in dependents may change the amount (if any) deducted from my wages for coverage.

Employer Signature: _____ Date: _____

Member (Employee) Signature: _____ Date: _____

Comments: _____

Please mail original Change Form to Evergreen within 31 days of qualifying event date.

SEE REVERSE SIDE FOR RIGHTS AND OBLIGATIONS

POST OFFICE BOX 100 COLUMBUS, GEORGIA 31902-0100 TELEPHONE 706-660-6175 FAX 706-660-6515

White- Evergreen Yellow-Employer

RIGHTS AND OBLIGATIONS

I declare all statements contained in this entire form are true and correct to the best of my knowledge and belief and that no material information has been withheld or omitted.

I hereby authorize any Physician, Medical Practitioner, Hospital, Clinic, Veterans Administration Facility, other medical and/or medically related Facility, Insurance or Reinsurance Company, or Consumer Reporting Agency, to release to Evergreen Health Plan, Inc., or its legal representative, any and all such information as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including Drug or Alcohol Abuse, and/or treatment of myself, spouse or my minor children and other non-medical information of myself, spouse, and/or my minor children. I understand that I may request a copy of this authorization at any time. I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for two years from the date signed.

I authorize My Employer to deduct the necessary contribution toward the premium. I reserve the right to revoke this deduction authorization at any time upon my written notice. This application will be part of the contract. Coverage is effective only after approval of Evergreen Health Plan, Inc. and satisfaction of any probationary period.

ABBREVIATED NOTICE OF PRIVACY POLICY

We value you as a customer and take your personal privacy seriously. We will inform you of our policies for collecting, using, securing, and sharing nonpublic personal information ("customer information") the first time we do business and every year that you are an Evergreen customer.

OUR PRIVACY PRINCIPLES

- We do not sell customer information.
- We do not provide customer information to persons or organizations outside our Evergreen family of companies who are doing business on our behalf, for their own marketing purposes.
- We contractually require any person or organization providing products or services to customers on our behalf to protect the confidentiality of Evergreen customer information.
- We do not share customer medical information with anyone within the Evergreen family of companies, unless you expressly authorize it, or unless it is permitted or required by law, or unless you insurance policy contract with us permits us to do so.
- We afford prospective and former customers the same protections as existing customer with respect to the use of personal information.

We maintain physical, electronic, and organizational safeguards to protect customer information. We continually review our policies and practices, monitor our computer networks, and test the strength of our security in order to help us ensure the safety of customer information.