ALTIUS
A Coventry Health Care Plan

10421 South Jordan Gateway
Suite 400
South Jordan, Utah 84095

CHANGE/DELETE FORM

Incomplete forms will delay the enrollment process

PLEASE PRINT

For Office Use Only

Group No. _____

Effective Date _____

Employer: _____

Employee Name:_____ Social Security Number: _____

Please check the type of change requested. Complete the appropriate information below.

❖ CHANGE/CORRECTION

❑ Name Change/Correction

From: _____

_____

To: _____

_____

❑ Address Change

❑ Telephone Number Change

❑ Primary Care Provider Change

❑ Enrollment Change:

- ❑ Cancel Medical Coverage
- ❑ Cancel Dental Coverage

❑ Other: _____

_____

_____

_____

❖ ADDITIONS

*** All additions, except newborns, require a completed Statement of Health.**

❑ Spouse

- ❑ Marriage (attach copy of Marriage Certificate)
- ❑ Loss of other Coverage (attach Certificate of Creditable Coverage or Loss of Coverage letter)

❑ Child/Children (check one)

- ❑ Newborn
- ❑ Adoption (attach copy of court documentation)
- ❑ Loss of Coverage (attach Certificate of Creditable Coverage)
- ❑ Court Order/Legal Guardianship (include copy of court documentation)
- ❑ Other

❖ DELETIONS

❑ Employee

❑ Employee and Family

❑ Employee and Spouse

❑ All Dependents

❑ Child/Children (list below)

❑ Spouse only (if applicable, include Divorce Decree)

Reason for deletion: _____

_____

_____

_____

_____

_____

_____

_____

❖ TERMINATION OF EMPLOYMENT

_____
Termination Date

Coverage will continue according to the guidelines established by your employer.

❑ Employee is electing COBRA or State Continuation of Coverage (New enrollment form required)

Effective date, other than open enrollment or termination, please attach applicable documentation.

Social Security #	Name Last	First	Initial	M/F	Date of Birth	Physician	Code
	Self						
	Spouse						
	Dependent						
	Dependent						
	Dependent						
	Dependent						
	Dependent						

New Address: _____ Apt #: _____ New Telephone: (_____) _____

City: _____ State: _____ Zip Code: _____

Employee Signature: _____ Date: _____

Effective Date of Change: _____

Employer Signature: _____