



CHARTER HEALTH PLAN  
A big idea for small business

# Employee Change Request

Please read instructions on opposite page before completing this form. Print clearly.

1. Employee Information					
Group Name: _____		For Charter Staff Use Only			
Charter Member ID #: _____		Effective Date: _____		Group Number: _____	
Last Name, First, MI:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Date of Birth: / /	
Home Address:		Apt. #:	City, State:		Zip Code:
2. Type of Activity					
Date of Event: ____/____/____ Reason: _____					
<input type="checkbox"/> Add Spouse		<input type="checkbox"/> Remove Spouse			
<input type="checkbox"/> Add Dependent		<input type="checkbox"/> Remove Dependent			
<input type="checkbox"/> Name Change from: _____ to: _____					
<input type="checkbox"/> Other: _____ Reason: _____					
3. Detailed Employee & Dependent Information				# of Family Members _____	
	Last Name, First, MI	Gender M F	Date of Birth MM/DD/YY	Social Security #	Primary Care Physician (PCP)
Spouse		<input type="checkbox"/> <input type="checkbox"/>	/ /		
Children		<input type="checkbox"/> <input type="checkbox"/>	/ /		
Attach Sheet to List Additional Children		<input type="checkbox"/> <input type="checkbox"/>	/ /		
		<input type="checkbox"/> <input type="checkbox"/>	/ /		
		<input type="checkbox"/> <input type="checkbox"/>	/ /		

If enrolling spouse and/or dependent(s), please complete health questionnaire.

**4. Dependent Information:**  N/A

Do any of the dependents listed in Section 3 live at another address? Yes  No

If yes, who and at what address?

Name:

Address:

\_\_\_\_\_  
\_\_\_\_\_

If any dependent's last name is different from yours, please explain the circumstances:

\_\_\_\_\_  
\_\_\_\_\_

**5. Other Coverage Information:**  N/A

Have any of the dependents listed in Section 2 had insurance coverage within the last 12 months? Yes  No

Is the coverage still active? Yes  No  If Yes, what is the Effective Date? \_\_/\_\_/\_\_\_\_ If No, what is the End Date? \_\_/\_\_/\_\_\_\_

If coverage is still active, please provide the following information along with a copy of your insurance ID card:

Person(s) Covered	Policy Holder Name	Insurance Company	Policy Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please include a copy of the Certificate of Portability if coverage has ended. If your dependent was covered under another health plan before enrolling with your current health plan you may be able to reduce or remove limitations on pre existing conditions. If your dependent did not have more than a 63 day lapse between prior coverage and current coverage, you may receive credit toward the time limit for a pre-existing condition. If your dependent were covered under another health plan before enrolling with your current health plan you may be able to reduce or remove limitations on pre existing conditions.

**6. Enrolling Employee Signature:**

I certify that all the information supplied on this application is true and complete.

Employee's Signature:

Optional E-Mail:

Date:

\_\_\_\_\_  
\_\_\_\_\_

**Change Request Instructions**

Section 1 - Employee Information: Complete all information in order for your application to be processed.

Section 2 - Type of Activity: To indicate whether you are Adding or Removing self and/or dependents, check the appropriate Add or Remove boxes. Check box(es) indicating reason(s) for submitting form, Date of Event and Reason (where requested).

Section 3 - Detailed Employee and Dependent Information: Print your full name along with the name(s) of your dependent(s), if applicable. Choose a primary care physician (PCP) from the available provider directory and write the physician's full name in the space provided.

Section 4 - Dependent Information: Complete these sections for all new applicants.

Section 5 - Other Coverage Information: Complete these sections for all new applicants.

Section 6 - Employee Signature: The Employee must sign and date the application for it to be processed.

Please complete the Health Questionnaire on the next two pages.

# Health Questionnaire

Please complete all questions for yourself (and your Dependents, if dependent's coverage is requested).

NAME	RELATIONSHIP	SSN	SEX	AGE	HEIGHT	WEIGHT
Employee						
Dependent	Spouse					
Dependent						
Dependent						
Dependent						
Dependent						

**A. Have YOU or any of your DEPENDENTS consulted with, been treated or examined by any physician or other practitioner for any of the following conditions within the past 10 years? If yes, please provide details below:**

MEDICAL CONDITION	YES	NO	MEDICAL CONDITION	YES	NO	MEDICAL CONDITION	YES	NO
1. Arthritis			19. Seizures			37. High Blood Pressure		
2. Rheumatoid Arthritis			20. Epilepsy			38. High Cholesterol		
3. Osteoarthritis			21. Parkinson's			39. Thyroid Disorder		
4. Back/Spinal Disorder			22. Alzheimer's Disease			40. Alcohol or Drug Dependency		
5. Back Strain / Sprain			23. Migraine Headaches			41. Attempted Suicide		
6. Scoliosis			24. Other Neurological Disorder			42. Anorexia/Bulimia		
7. Spina Bifida			25. Hemophilia			43. Depression		
8. Stroke			26. Kidney/Urinary Disorder			44. Other Mental/Behavioral Disorder		
9. Cancer, Leukemia, Melanoma			27. Tumors/Growths			45. Venereal Disease/STD		
10. Emphysema			28. Juvenile Diabetes			46. Deafness		
11. Chronic Bronchitis			29. Diabetes Mellitus			47. Ulcerative Colitis		
12. Asthma			30. Heart Attack/M.I.			48. Diverticulitis		
13. Other Lung Disorder			31. Coronary Artery Disease			49. Crohn's Disease		
14. Liver Disorder			32. Coronary Bypass Surgery			50. Gastric/Peptic Ulcer		
15. Congenital Disease/Defect			33. Congestive Heart Failure			51. Gastric Reflux/GERD		
16. Paralysis			34. Pacemaker			52. Other Bowel/Stomach Disorder		
17. Multiple Sclerosis			35. Ischemic Heart Disease			53. Premature Birth		
18. Cerebral Palsy			36. Other Heart Disorder			54. Other		

Do YOU or any of your DEPENDENTS have any transplanted organs? Yes  No

If Yes, please explain: \_\_\_\_\_

Check here if none

MEDICAL CONDITION NUMBER	TREATING PHYSICIAN	PERSON TREATED	TYPE OF TREATMENT	DATES OF TREATMENT

**B. Should you need more space to provide complete and accurate information, please attach a separate sheet with additional information, sign and date it and check this box.** \_\_\_\_\_

Please complete the information on the opposite page.

C. Please list all current or required medication(s) for you or any dependents. CHECK HERE IF NONE

EMPLOYEE OR DEPENDENT	CURRENT MEDICATION	DAILY DOSAGE	REASON FOR MEDICATION
Example: John Smith	Lipitor	10 mg once daily	High cholesterol

D. Have You or any Dependents tested positive for exposure to HIV infection or been diagnosed as having ARC or AIDS caused by HIV infection or other sickness or condition derived from such infection? Yes  No

E. Are You or any Dependents now pregnant? Yes  No  If "yes", what is the due date? \_\_\_\_\_  
 If "Yes", is this pregnancy high risk or complications anticipated? If "Yes", give name of patient and explanation:

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F. Have You or any Dependents received abnormal results from any diagnostic test (including but not limited to Blood Test, Urinalysis, EKG, Ultrasound) in the last 6 months? Yes  No  If "Yes", please give patient's name, date of service, type of test and results:

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G. Have You or any Dependents been advised to have any diagnostic test, medical evaluation, hospitalization or surgery in the next 12 months? Yes  No  If "Yes", please give the patient's name, date of service, type of service and reason for the service:

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Please Initial Each Box Below:

\_\_\_\_\_ I UNDERSTAND that this information will be used to determine premiums for coverage applied for.

\_\_\_\_\_ I UNDERSTAND that I or my dependents may be required to provide additional information regarding any of the above responses, including providing a medical release to obtain medical records. I have read, or have had read to me, all information contained in this form and such information is accurate and complete to the best of my knowledge.

\_\_\_\_\_ I UNDERSTAND that I might be asked to complete a medical questionnaire by First Service Administrators. This request for additional medical information must be completed and returned within 30 days to the Third Party Administrator. Failure to comply may result in termination of your coverage.

\_\_\_\_\_ I UNDERSTAND that if I have made any material false statement, misrepresentation or omission on this form, which changes the risk assumed by this plan, I may lose Varsity Health's CHARTER Plan coverage. Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree (under Florida Law Chapter 95-340).

Once you are enrolled, you will receive a letter from First Service Administrators, Inc. (FSAI) requesting additional information about your health status. *It is very important that you complete this form and mail back to FSAI as soon as possible.* Completion and receipt of this form will be necessary for your health care claims to be paid.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (if applicable)