



HealthAmericaOne Insurance Trust  
 Underwritten by Coventry Health and Life Insurance Company

## 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):

- Contact Information / Name Change    Newborn Addition    Remove / Move Dependents    Decrease Benefits / Cancel Coverage    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 (   ) -   -
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**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
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New home address (Street, City, State, ZIP)	New mailing address (Street, City, State, ZIP)
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**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
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**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)
			<input type="checkbox"/> Move to own policy <input type="checkbox"/> Move to a new policy with other dependents <input type="checkbox"/> Remove from policy; discontinue coverage	
			<input type="checkbox"/> Move to own policy <input type="checkbox"/> Move to a new policy with other dependents <input type="checkbox"/> Remove from policy; discontinue coverage	
			<input type="checkbox"/> Move to own policy <input type="checkbox"/> Move to a new policy with other dependents <input type="checkbox"/> 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.

<input type="checkbox"/> Decrease my benefits. Requested Effective Date _____ Change plan to: _____	<input type="checkbox"/> Cancel my coverage. Requested date of cancellation _____ Reason for cancellation: _____
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**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.

**OHIO:** ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.  
**PENNSYLVANIA:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES

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

\*\*Required age 18 and over.

Submit your completed Change Request Form to:  
 E-mail: [planchanges@cvty.com](mailto:planchanges@cvty.com)  
 FAX: 877-815-8747  
 Address: ATTN: Plan Changes  
 HealthAmericaOne Individual Underwriting  
 P.O. Box 61440, TecPort Drive Harrisburg, PA  
 17106-1440