



Member Status Change Form

PCP Change
 Removing a Dependent
 Termination of Employee Coverage
 Address/Name Change

Employer's Name	Group Number	Name of Employee	Member Identification Number	
A) PRIMARY CARE PHYSICIAN (PCP) CHANGE - Change PCP for only the following members:				
	Name	Member Identification Number	New VISTA PCP ID Number	
1				
2				
3				
B) REMOVING COVERAGE FOR EMPLOYEE OR DEPENDENTS - Any changes must be reported within thirty (30) days of the event.				
			Reason: (Please check and state effective date)	
1	Dependent Last Name	First Name	M.I.	<input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Other
	Birth Date	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to applicant: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
2	Dependent Last Name	First Name	M.I.	<input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Other
	Birth Date	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to applicant: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
3	Dependent Last Name	First Name	M.I.	<input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Other
	Birth Date	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to applicant: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
C) ADDRESS OR NAME CHANGE - Please attach proper legal documentation (i.e., marriage certificate, driver's license, court order, etc.)				
Name Changed From (Former Name)		Name Changed to (New Name)		Telephone #
Address Changed (New Home Address)			City	State Zip

I hereby represent to you that all information furnished by me herein is true and complete to the best of my knowledge. I acknowledge and accept the provisions of this form.
 I understand that the information provided is subject to verification by Vista Healthplan, Inc. and Vista Healthplan of South Florida, Inc. (hereinafter referred to collectively as VISTA). Failure to provide timely information on removing of an employee or dependent may result in an adjustment to the requested effective date of termination of the applicable coverage at the discretion of VISTA.
 I understand that any change resulting in an adjustment of the premium must be approved by the employer before submitting to VISTA.
 I understand that any change approved by VISTA will not alter the rights and responsibilities of the member under the Group Agreement/Certificate of Coverage.
Any person who knowingly and with intent to injure, defraud or deceive an insurer files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony of the third degree.

Employee Signature _____

Date _____

Employer Verification _____

Date _____