



# Preferred Health Address Change Form

## Section One - Who is Changing Their Address?

The purpose of this form is to change the address of:

- All persons covered under this policy, OR
  - Employee or Member
  - Spouse (or Domestic Partner, if applicable)
  - Dependents, please list name(s):

\_\_\_\_\_

\_\_\_\_\_

## Section Two - Employee/Group or Member Information

**Important:** If you have group coverage, notify your employer regarding your new address.

Name of Employee or Member, if Individual Plan:	_____	Employee/Member's Phone #:	_____
If Group Plan, Name of Employer:	_____	Employee/Member's ID Number:	_____

## Section Three - Address Information

Old Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

New Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Effective Date of Change: \_\_\_\_\_

## Section Four - Signature & Date

***By signing and dating this form, I am verifying that I have the legal authority in which to make the above changes.***

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

Preferred Health Internal Use Only		
<input type="checkbox"/> GBAS System:	_____	_____
	Date	By