MEMBER CHANGE FORM

Reset Form | Print Form

UHA HEALTH INSURANCE

SUBSCRIBER INFORMATION

1 Fill-in all the requested information

Subscriber's Member ID: _____ - _____ Last Name: _____ First Name: _____

TRANSFER TO NEW DIVISION?

2 If the subscriber is transferring to a different division, enter the old and new divisions

Old Group/Division #: _____ / _____

New Group/Division #: _____ / _____

Effective Date: ___ / ___ / _____

CHANGE PLAN?

Enter the new medical coverage

3

Medical Plan: ☐ UHA 600 ☐ UHA 3000

Other Benefits: ☐ Drug ☐ Vision ☐ Dental

UPDATE SUBSCRIBER INFORMATION?

Check one or more boxes to update all the information requested.

Update subscriber information? Visit Online Member Services site at https://portal.uhahealth.com/Member/Account/LogOn

☐ NAME CHANGE ☐ ADDRESS CHANGE ☐ EMAIL CHANGE ☐ PHONE # CHANGE ☐ SOCIAL SECURITY CORRECTION

4

Social Security #: ___ - ___ - _____

Last Name: _____

First Name: _____

Mailing Address: _____

City: _____ State: ___ Zip Code: _____

Physical Address: _____

☐ same as mailing City: _____ State: ___ Zip Code: _____

Contact Number: ___ - ___ - _____ E-mail Address: _____

UPDATE SPOUSE, CIVIL UNION PARTNER, OR DEPENDENT INFORMATION?

5 Complete only if dependent's information needs to be updated.

Select the box: ☐ NAME CHANGE ☐ SOCIAL SECURITY CORRECTION

Member ID: _____ - _____ Social Security #: ___ - ___ - _____

Last Name: _____

First Name: _____

Birth Date: ___ / ___ / _____ Gender: ☐ Female ☐ Male

Physical Address: _____

☐ same as mailing City: _____ State: ___ Zip Code: _____

REQUIRED SIGNATURE

6

The Group Administrator and subscriber of the above named UHA Member Group certifies by signature below that the above named subscriber is a bona fide employee as defined by the Hawaii Prepaid Healthcare Act. UHA may terminate coverage for any ineligible enrollee upon confirmation of ineligibility. If enrollment of the above named enrollee(s) is found to be based on fraud or intentional misrepresentation of a material fact by the employer, coverage for the Member Group and/or the enrollee(s) may be terminated by UHA. In the event of termination, the above named Member Group agrees that any benefit payments made by UHA on behalf of the ineligible enrollee(s) must be returned in full to UHA by the ineligible enrollee(s) and/or the employer. UHA shall return all premiums paid by the employer with respect to the ineligible enrollee(s) upon termination of coverage and reimbursement of benefit payments made by UHA.

Under penalties of perjury, I certify that the social security number shown on this form is correct for the subscriber, their spouse, partner and/or dependent (or they are waiting for a number to be issued). I also certify that the information I have provided is the most current and accurate information.

Group Administrator Signature: _____ Date: _____

Prepared By: _____ Contact Number: _____

Member Change Instructions

① SUBSCRIBER INFORMATION:
Provide the subscriber's member ID and full name.
One subscriber per form.

② TRANSFER TO NEW DIVISION:
Enter the old group/division number.
Provide new group/division number and effective date of change.

③ CHANGE PLAN:
Check off one or more items to change pertaining to the subscriber mentioned on this form.
Provide all information requested.

④ UPDATE SUBSCRIBER INFORMATION:
Check off one or more items to change pertaining to the subscriber mentioned on this form.
Provide all information requested.

⑤ UPDATE SPOUSE, CIVIL UNION PARTNER, OR DEPENDENTS INFORMATION:
Check off one or more items to change pertaining to the member mentioned on this form.
Provide all information requested.

⑥ GROUP ADMINISTRATOR SIGNATURE:
Form must be signed and dated by an authorized group administrator.

To ensure proper processing, all required fields must be completed and proper documentation submitted.
Fax or mail completed forms with necessary documentation to:

UHA Employer Services
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

Toll-free fax: (877)222-3198

If you have any further questions contact Employer Services.
Phone: (808) 532-4007; Toll-free phone: (800) 458-4600 Ext. 299; uhahealth.com