UHA HEALTH INSURANCE

Member Change Form

Review Member Change Instructions on the next page **before** filling out this form.

You can also manage your employee's information through UHA's Online Enrollment Services! *See instructions for details.*

SUBSCRIBER INFORMATION

1

Fill in all 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?

3

Enter the new medical coverage:

Medical Plan: ☐ UHA 600 ☐ UHA 3000 ☐ UHA One Plan

Other Benefits: ☐ Drug ☐ Vision ☐ Dental ☐ *Pediatric Dental

*Pediatric Dental coverage for small groups only (1 - 50 Employees)

UPDATE SUBSCRIBER INFORMATION?

Check one or more boxes to indicate the information being updated.

☐ NAME ☐ ADDRESS ☐ EMAIL ☐ PHONE # ☐ SOCIAL SECURITY # ☐ GENDER

4

Social Security #: ___ - ___ - _____ Gender: ☐ Female ☐ Male

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 DEPENDENT INFORMATION?

Complete only **if** spouse, civil union partner, or dependent child information needs to be updated.

Select the box: ☐ NAME ☐ SOCIAL SECURITY CORRECTION ☐ GENDER

5

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

Last Name: _____

First Name: _____

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

Physical Address: _____

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

6

REQUIRED SIGNATURE

The Group Administrator for the Member Group certifies by signature below that the information provided above is the most current and accurate information and the information complies with the Enrollee eligibility and termination requirements in the contract between UHA and Member Group. Eligibility requirements include that the subscriber is a bona fide "regular employee" as defined by the Hawaii Prepaid Healthcare Act (HRS Chapter 393) and any dependent is an Eligible Dependent of the subscriber. The Group Administrator understands that UHA may terminate coverage for any ineligible Enrollee upon confirmation of ineligibility.

If UHA finds enrollment of Enrollee(s) to be based on False Statements, coverage for the Member Group and/or the Enrollee(s) may be retroactively terminated. For retroactive termination, UHA shall return all premiums paid for the time period after the termination date and the Member Group and/or ineligible Enrollee(s) shall return any benefit payments made by UHA for the same time period.

Under penalty of perjury, the Group Administrator certifies that the social security number shown on this form is correct for the subscriber and/or dependent (or they are waiting for a number to be issued).

Group Administrator Signature: _____ **Date:** _____

NOTE: Verifiable digital signatures with date stamp and name of signor accepted as well as certain electronic signatures.

Prepared By: (Print Name) _____ 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 DEPENDENT INFORMATION:** Check off one or more items to change pertaining to the spouse, civil union partner, or dependent child mentioned on this form. Provide all information requested.

⑥ **GROUP ADMINISTRATOR SIGNATURE:**
Form must be signed and dated by an authorized group administrator. Capitalized words in this section are defined in the Agreement for Group Health Plan, which is the contract between UHA and the Member Group.

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

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

Toll-free fax: (877)222-3198

Email: ES@uhahealth.com

You can also conveniently submit changes for employee information through **UHA's Online Enrollment Services**. Termination of employees and dependents takes approximately one business day. Please note that retroactive terminations **cannot** be added through the Online Enrollment Services System.

To sign up, complete the **Online Employer Access Authorization and Certification Form** (uhahealth.com/wp-content/uploads/online-agreement-auth-cert-form.pdf) or contact us for more information.

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