



# Arizona Change/Deletion Form

## FOR PACIFICARE OFFICE USE ONLY

EFFECTIVE DATE OF CHANGE/DELETE (REQUIRED)

Employer approval

Process Date

Processor

Type or print with ballpoint pen. Do not write in shaded areas. Incomplete information will delay the enrollment process.

### A. Employee Information

Employee Last Name	First Name	MI	Social Security Number	Sex	Employer Name	HMO Group No.	Life Group No.	Subgroup/Location No.
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### B. Change in Information (please check the type of change requested and complete the appropriate information below)

<input type="checkbox"/> Name Change (Attach Legal Documentation)	<input type="checkbox"/> HMO Network, Change To _____	<input type="checkbox"/> Social Security Number Correction (Attach Legal Documentation)	<input type="checkbox"/> Change Subgroup from _____ to _____
<input type="checkbox"/> Birth Date Correction	<input type="checkbox"/> HMO Primary Care Physician Change	<input type="checkbox"/> Life Insurance Beneficiary Change	<input type="checkbox"/> Other _____
<input type="checkbox"/> Address Change	<input type="checkbox"/> HMO Primary Care Dentist Change	<input type="checkbox"/> Change Group Number from _____ to _____	
<input type="checkbox"/> Home Phone Number Change	<input type="checkbox"/> Add Dental: <input type="checkbox"/> HMO <input type="checkbox"/> Indemnity		
<input type="checkbox"/> Reinstate on PacifiCare	<input type="checkbox"/> Delete Dental: <input type="checkbox"/> HMO <input type="checkbox"/> Indemnity		

Street Address	Apt.	City	State	Zip Code	Country	Home Phone Number
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Beneficiary's Last Name	First Name	MI	Social Security Number	Relationship	Date Stamp (For PacifiCare Use)
Street Address	Apt.	City	State	Zip Code	

### C. Employee/Dependent Information

Medical Add	Coverage Delete	Dental Add	Coverage Delete	Relationship	Last Name	First Name	MI	Sex	Social Security #	Birth Date (MM/DD/YYYY)	Network/Code	If electing HMO Primary Care Physician provide			
												Last Name	First Name	MI	✓
				Self (00)											
				Spouse (02)											
				Dependent (03)											
				Dependent (04)											
				Dependent (05)											
				Dependent (06)											
				Dependent (07)											

ADDITIONAL INFORMATION/EXPLANATION

Employee Signature (If employee is not available, employer may sign)

Date

HMO Product is offered/underwritten by PacifiCare of Arizona. PPO, Indemnity and Life Products offered/underwritten by PacifiCare Life Assurance Company.

White: PacifiCare

Yellow: PacifiCare Life Assurance Company

Pink: Employer

Green: Subscriber