

Change Request Form

Important: Complete any applicable sections in ink, and sign and date at bottom of page.
* indicates required information

* ID Number: _____

* Full Name: _____
Last First M.I.

NAME CHANGE:

Important: If changing name, please indicate new name above.

Change my name from: _____ to: _____

ADDRESS CHANGE:

New Address:

Address: _____
Mailing Address or P.O. Box

_____ *City State ZIP Code*

Home Phone: () _____ Alternate Phone: () _____

TOBACCO USE CHANGE:

Change my Tobacco Use status to:

- Tobacco User
 Non-Tobacco User (must attach a letter from your Physician stating that you have not used tobacco in the last 12 months)

BILLING METHOD CHANGE:

Change my billing method to:

- Quarterly Monthly Bank Draft (must attach a completed Pre-Authorized Bank Draft Form and voided check)

CANCEL COVERAGE:

Check box and fill in date of desired cancellation: (Note: CHIP can only cancel policies on the last day of the month.)

- Cancel my CHIP Policy effective: _____
Reason for cancellation: Medicare - Effective _____ Other Reason _____
 Other Insurance - Effective _____

SIGNATURE AND DATE:

* Signature of Policyholder **X** _____ Date Signed _____

Parent/Guardian Signature **X** _____ Date Signed _____
*If policy for a minor or incompetent