Member Status Change Form

□ PCP Change □ Adding a Dependent □ Address/Name Change
□ Removing/Termination of Dependents □ Termination of Employee Coverage □ Reinstate Coverage

NAME OF EMPLOYEE	EMPLOYER'S NAME	MEMBER IDENTIFICATION NUMBER

I. PRIMARY CARE PHYSICIAN (PCP) CHANGE - Change PCP for only the following members:

Name	Member Identification Number	New VISTA PCP ID Number
1.		
2.		
3.		

II. ADDING COVERAGE FOR EMPLOYEE OR DEPENDENTS - Any changes must be reported within thirty (30) days of the event and appropriate documentation, i.e., birth certificate, marriage license, etc. must be forwarded to VISTA with this form.

Name Of Employee / Dependent	Birth Date	Effective Date	New VISTA PCP ID Number	Reason: (Please check)
1.				□ MARRIAGE □ BIRTH □ OTHER
2.				□ MARRIAGE □ BIRTH □ OTHER
3.				□ MARRIAGE □ BIRTH □ OTHER

EXPLANATION OF OTHER:

III. REMOVING/TERMINATION OF COVERAGE FOR EMPLOYEE OR DEPENDENTS - Any changes must be reported within thirty (30) days of the event and appropriate documentation, i.e., birth certificate, marriage license, etc. must be forwarded to VISTA with this form.

Name Of Employee / Dependent	Birth Date	Effective Date	Reason: (Please check)
1.			□ DIVORCE □ DEATH □ OTHER
2.			□ DIVORCE □ DEATH □ OTHER
3.			□ DIVORCE □ DEATH □ OTHER

EXPLANATION OF OTHER:

IV. ADDRESS OR NAME CHANGE - Please attach proper legal documentation (i.e., marriage certificate, driver's license, court order, etc.)

NAME CHANGED FROM (FORMER NAME)	NAME CHANGED TO (NEW NAME)	
ADDRESS CHANGED (NEW HOME ADDRESS)	CITY	
STATE	ZIP	TELEPHONE #

I hereby represent to you that all information furnished by me herein is true and complete to the best of my knowledge. I acknowledge and accept the provisions of this form.

I understand that the information provided is subject to verification by Vista Healthplan, Inc. (VISTA) or Vista Healthplan of South Florida, Inc. (VISTA-SFL) or Vista Insurance Plan, Inc. (VIP). Failure to provide timely information on removing/ termination of an employee or dependent may result in an adjustment to the requested effective date of termination of the applicable coverage at the discretion of VISTA/VISTA-SFL/VIP.

I understand that any change resulting in an adjustment of the premium must be approved by the employer before submitting to VISTA/VISTA-SFL/VIP.

I understand that any change approved by VISTA/VISTA-SFL/VIP will not alter the rights and responsibilities of the member under the Group Master Contract / Certificate of Coverage.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony of the third degree.

Employee Signature _____ Date _____

Employer Verification _____ Date _____

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