CALIFORNIA

PacifiCare®

Change Request Form

Important: Please print or type all sections in black ink

Current Personal Information

PacifiCare ID # (if applicable)	Employer Name		Group # (if applicable)
Last Name	First Name	MI	Social Security #
Address / Apt #	City	State	ZIP
Home Telephone ( )	Work Telephone ( )		Extension

Change of Personal Information

☐ Change my address/phone as indicated above.
☐ Change my name as shown above. My former name was _____

Change of Dependent Status

Newborn, adoption, marriage, open enrollment, other

☐ Add ☐ Delete	Relationship	Last Name	Date of Birth (Month - Day - Year) - -	Effective Date of Coverage - -
	☐ Female ☐ Male	First Name MI	PCP or Medical Group Number	**Reason** ☐ Newborn ☐ Adoption ☐ Marriage ☐ Open enrollment ☐ Other*
☐ Add ☐ Delete	Relationship	Last Name	Date of Birth (Month - Day - Year) - -	Effective Date of Coverage - -
	☐ Female ☐ Male	First Name MI	PCP or Medical Group Number	**Reason** ☐ Newborn ☐ Adoption ☐ Marriage ☐ Open enrollment ☐ Other*

* For "Other," please attach a letter of explanation.

Change of Other Insurance Carrier Information

☐ Add ☐ Delete	Last Name	Social Security Number - -	Health Coverage Name	Other Employer Name and Address
	First Name MI	Date of Birth (Month - Day - Year) - -	Policy No./Effective Date	
☐ Add ☐ Delete	Last Name	Social Security Number - -	Health Coverage Name	Other Employer Name and Address
	First Name MI	Date of Birth (Month - Day - Year) - -	Policy No./Effective Date	

Change of Plan Type

Plan changes can only be made during open enrollment. Before you change your plan, please confirm that your employer offers these plans. All family members must be in the same plan.

From (check one)

☐ PacifiCare SignatureValue℠ (HMO)
☐ PacifiCare SignaturePOS℠
☐ PacifiCare SignatureOptions℠ (PPO)*
☐ PacifiCare SignatureIndependence℠ (Indemnity)*
☐ PacifiCare SignatureFreedom℠ (SDHP)*

To (check one)

☐ PacifiCare SignatureValue℠ (HMO)
☐ PacifiCare SignaturePOS℠
☐ PacifiCare SignatureOptions℠ (PPO)*
☐ PacifiCare SignatureIndependence℠ (Indemnity)*
☐ PacifiCare SignatureFreedom℠ (SDHP)*

If you are changing your plan type from a PPO or Indemnity plan to an HMO or POS plan, complete the "Change of Primary Care Physician" section on the reverse of this form.

Signature required for all changes on reverse side of form

* Underwritten by PacifiCare Life & Health Insurance Company

Employee Name	Social Security #	Group # (if applicable)

Change of Primary Care Physician (PCP)/Medical Group** (HMO/POS Only)

If your change request is received by PacifiCare by the 15th of the month, the change will be effective the first of the following month; if your request is received by PacifiCare after the 15th of the month, the change will be effective the first day of the subsequent month. For Example: If your PCP change request is received January 14, the change is effective February 1. If your request is received January 20, the change is effective March 1. Some restrictions apply. Please ask your employer or call PacifiCare's Customer Service department.

PCP Selection (HMO/POS Only)

Complete this "PCP Selection" section if you are changing your plan type to an HMO or POS plan from a PPO or Indemnity plan, or if you are currently enrolled in an HMO or POS plan and want to change your current PCP.

- Please select a doctor near your home for you and each of your family members from your PacifiCare *Provider Directory* and write the name and number below.
- Please indicate your first and second choice.
- You may choose a different doctor for each member of your family.
- Did you select a doctor? If not, we will select one for you.
- Newborns remain enrolled with the mother's PCP from birth until discharged from the hospital. Please refer to your *Combined Evidence of Coverage and Disclosure Form* for further details.

Note: Over age dependents require proof of full-time student status or permanent disability within 31 days of enrollment. Form cannot be processed if information is incomplete.

1	**Self** ☐ Female ☐ Male	Last Name First Name MI	Social Security Number - - Date of Birth (Month - Day - Year) - -	Primary Care Physician Name Medical Group Name	PCP # – OR – Group #	Primary Care Physician (PCP) Number Medical Group Number	Existing Patient? ☐ Yes ☐ No
2	**Spouse** ☐ Female ☐ Male	Last Name First Name MI	Social Security Number - - Date of Birth (Month - Day - Year) - -	Primary Care Physician Name Medical Group Name	PCP # – OR – Group #	Primary Care Physician (PCP) Number Medical Group Number	Existing Patient? ☐ Yes ☐ No
3	Relationship ☐ Female ☐ Male	Last Name First Name MI	Social Security Number - - Date of Birth (Month - Day - Year) - -	Primary Care Physician Name Medical Group Name	PCP # – OR – Group #	Primary Care Physician (PCP) Number Medical Group Number	Existing Patient? ☐ Yes ☐ No
4	Relationship ☐ Female ☐ Male	Last Name First Name MI	Social Security Number - - Date of Birth (Month - Day - Year) - -	Primary Care Physician Name Medical Group Name	PCP # – OR – Group #	Primary Care Physician (PCP) Number Medical Group Number	Existing Patient? ☐ Yes ☐ No

**All medical group changes must be approved by PacifiCare before becoming effective. All ongoing medical care being received from referral providers must be discontinued by the effective date of your medical group change. Please have your condition evaluated by your new primary care physician.

Signature – Required for all changes

Your Signature		Date
Employer Verification/Authorized Signature	Phone # ( )	Date

PacifiCare Use Only

PAC Effective Date	Verified By	Date Verified

PacifiCare SignatureValue℠ (HMO)
and PacifiCare SignaturePOS℠ (POS)
5701 Katella Avenue
Cypress, CA 90630
Attn: Membership Accounting
800-624-8822 – HMO
800-913-9133 – POS
www.pacificare.com

PacifiCare SignatureOptions℠ (PPO),
PacifiCare SignatureIndependence℠ (Indemnity)
and PacifiCare SignatureFreedom℠ (SDHP)
P.O. Box 6098
Cypress, CA 90630
866-316-9776 – PPO/Indemnity
866-867-0700 – SDHP
www.pacificare.com

CM-403-42883.50
PC3304-005 Rev. 4/03