

## Demographic Change/Termination Form

Use this form to indicate changes to your member information, delete dependents or cancel your coverage. Additions to enrollment must use enrollment form.

### A. EMPLOYEE INFORMATION (this section must be completed)

First Name	M.I.	Last Name	Birth Date	Social Security Number
			/ /	
Medica Member ID Number	Home Telephone		Work Telephone	

### B. CHANGES IN COVERAGE (this section must be completed)

Effective Date of Change/Termination: / / (Terminated members will be covered through the end of the month.)

Change Address to:

Change Name from: to:

Change Clinic (indicate within table below)

Terminations: (check one)

<input type="checkbox"/> Cancel all coverage	Date coverage became ineligible: / /	Reason:	<input type="checkbox"/> Employee terminated	<input type="checkbox"/> Enrollment fraud	<input type="checkbox"/> Dependent ineligible
<input type="checkbox"/> Delete dependents listed below		<input type="checkbox"/> Employee ineligible	<input type="checkbox"/> Moved out of service area	<input type="checkbox"/> Death	
		<input type="checkbox"/> Other:			

#### List all family members to be changed or deleted.

	First Name	M.I.	Last Name	Relationship	Sex	Birth Date	Clinic Name	Clinic Number
1	<input type="checkbox"/> Change <input type="checkbox"/> Delete				M F	/ /		
	Address (if change):							
2	<input type="checkbox"/> Change <input type="checkbox"/> Delete				M F	/ /		
	Address (if change):							
3	<input type="checkbox"/> Change <input type="checkbox"/> Delete				M F	/ /		
	Address (if change):							
4	<input type="checkbox"/> Change <input type="checkbox"/> Delete				M F	/ /		
	Address (if change):							
5	<input type="checkbox"/> Change <input type="checkbox"/> Delete				M F	/ /		
	Address (if change):							

### C. EMPLOYEE SIGNATURE

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

### TO BE COMPLETED BY EMPLOYER

Full Company Name	Branch/Division	Group Number
Group Administrator Signature	Employer's Telephone	Date

Employer or Group Administrator, please fax completed forms to: 248-733-6064  
or, mail to: Medica  
PO Box 30986  
Salt Lake City, UT 84130-0986