ENROLLEE CHANGE FORM

WSHIP
Attn: Enrollment
P.O. Box 1090
Great Bend, KS 67530
1-800-877-5187
Fax 620-793-1199
www.wship.org

MEMBER INFORMATION
(Required for all changes)

LAST NAME | FIRST NAME | MIDDLE

ADDRESS

CITY | STATE | ZIP

MEMBER ID NUMBER | BIRTH DATE | TELEPHONE

Address Change?
- ◇ YES
- ◇ NO

◇ PREMIUM CYCLE

Changes must be received prior to the 20th of the month for processing and to be effective the following month.

Please change my premium payment cycle to:

- ◇ Monthly - Automatic Withdrawal (must complete Automatic Bank Withdrawal Authorization Form)
- ◇ Quarterly
- ◇ Semi-Annual
- ◇ Annual

A change from the monthly ACH billing cycle will be effective the 1st of the month of the following calendar quarter.

◇ NOTIFICATION OF NEWBORN/FOSTER/ ADOPTED DEPENDENT

Coverage is subject to premium payment from birth or adoption. For coverage beyond the first 31 days, an application must be submitted for a newborn/foster/adopted dependent within 31 days.

LAST NAME | FIRST NAME | MIDDLE

DATE OF BIRTH | DATE OF PLACEMENT/ADOPTION

◇ CANCELLATION OF COVERAGE

I wish to cancel my Washington State Health Insurance Pool Coverage effective: _________________ (Termination is subject to policy guidelines)

My reason for cancellation is: ____

I understand non-Medicare coverage is not available for re-enrollment due to new eligibility rules effective 01/01/2014. (Non-Medicare plans include Standard, PPO, Limited A and Limited B)

I understand I will not be allowed to reapply to WSHIP for 12 months following the effective date of this cancellation.

I hearby certify that the foregoing statements are true and accurate to the best of my knowledge and belief. I understand that no change will become effective until the first day of the month following approval by the Washington State Health Insurance Pool. I further understand that if I am no longer a resident of the State of Washington, I will notify the Washington State Health Insurance Pool and my benefits will end.

SIGNATURE OF ENROLLEE		SIGNATURE OF PARENT OR LEGAL GUARDIAN (if enrollee is under the age of 18 or legally incompetent)	
X	Date	X	Date

RETURN THIS FORM TO THE ADDRESS ABOVE

DO NOT SEND PAYMENT WITH THIS FORM