WASHINGTON STATE HEALTH INSURANCE POOL

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

Address Change?
◇ YES
◇ NO

CITY | STATE | ZIP

MEMBER ID NUMBER | BIRTH DATE | TELEPHONE

◇ **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

X Date

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

X Date

RETURN THIS FORM TO THE ADDRESS ABOVE
DO NOT SEND PAYMENT WITH THIS FORM