My**Priority** change form

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PriorityHealth

You can only use this form if you have a MyPriority plan with coverage that took effect on January 1, 2014 or after.

Member Information

Member's last name	First name	Middle initial	Social security number	Contract number

Changes (Please complete only those changes which apply.)

☐ Address/phone/email change (Moving to a new area within the state of Michigan may result in a rate adjustment).

Street Address			City
State	**Zip code**	**Phone number that we may use to contact you:** ( ) ☐ Landline (home phone) ☐ Cell phone	**Alternate number that we may use to contact you (optional):** ( ) ☐ Landline (home phone) ☐ Cell phone

Email	Primary care provider	PCP address

☐ Name change (You must include proof of name change with this form. For example: Driver's license, marriage license, judgement of divorce, Social Security Card, etc.)

New last name	Former last name

☐ Add or Remove a spouse or dependent(s). You can only add a spouse or dependent(s) within 60 days of a qualifying life event. For example: marriage, birth, adoption, legal guardianship, placement for adoption or placement for foster care.

☐ Add Date of qualifying life event:	☐ Remove Remove as of date:	Reasons ☐ Death ☐ Divorce ☐ Other:

1

Spouse last name		First name	Middle initial	Social security number
Birth date	**Sex** ☐ Male ☐ Female	**Relation to member**	**Primary care provider**	
Has this dependent ever seen this provider? ☐ Yes ☐ No		**PCP address**		

Tobacco use: ☐ Yes ☐ No (Answer only if you are 21 or older)
Check "yes" if you've used tobacco products four or more times per week within the last six months (for non-religious and non-ceremonial uses).

2

Dependent last name		First name	Middle initial	Social security number
Birth date	**Sex** ☐ Male ☐ Female	**Relation to member**	**Primary care provider**	
Has this dependent ever seen this provider? ☐ Yes ☐ No		**PCP address**		

Tobacco use: ☐ Yes ☐ No (Answer only if you are 21 or older)
Check "yes" if you've used tobacco products four or more times per week within the last six months (for non-religious and non-ceremonial uses).

3

Dependent last name		First name	Middle initial	Social security number
Birth date	**Sex** ☐ Male ☐ Female	**Relation to member**	**Primary care provider**	
Has this dependent ever seen this provider? ☐ Yes ☐ No		**PCP address**		

Tobacco use: ☐ Yes ☐ No (Answer only if you are 21 or older)
Check "yes" if you've used tobacco products four or more times per week within the last six months (for non-religious and non-ceremonial uses).

4

Dependent last name		First name	Middle initial	Social security number
Birth date	**Sex** ☐ Male ☐ Female	**Relation to member**	**Primary care provider**	
Has this dependent ever seen this provider? ☐ Yes ☐ No		**PCP address**		

Tobacco use: ☐ Yes ☐ No (Answer only if you are 21 or older)
Check "yes" if you've used tobacco products four or more times per week within the last six months (for non-religious and non-ceremonial uses).

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Preferred method of contact	Authorized representative	
	Name	Address
☐ Phone ☐ Email ☐ Regular mail	Email	Phone number that we may use to contact you: ( ) ☐ Landline (home phone) ☐ Cell phone

Authorization

I authorize Priority Health to make the changes indicated above for me and my dependents. I understand that Priority Health may request pertinent sworn statements if needed and that I must sign and date this form before it will be processed.
Priority Health requires proper handling of personal health information for our members. Details of our confidentiality policies and procedures are available upon request.

x _____
Member signature Date

In accordance with the Genetic Information Nondiscrimination Act (GINA) of 2008, Priority Health requests that you not include any genetic information on this form. Genetic information includes any genetic testing results of either yourself or a family member, your family health history or any requests for or receipt of genetic services.

The term "Priority Health"refers to three corporations: "Priority Health," "Priority Health Managed Benefits, Inc." and "Priority Health Insurance Company." Priority Health is a registered trademark and is used by permission of the owner.

Priority Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia en su idioma. Consulte al número de Servicio al Cliente que está en la parte de atrás de su tarjeta de identificación de miembro. (TTY: 711).

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. يرجى الاتصال برقم خدمة العملاء على الجانب الخلفي من بطاقة عضويتك الشخصية. (رقم هاتف الصم والبكم: 711).