Add/Change/Delete Form

A. Individual	Group
Member Insurance ID Number	*Group ID Number*
Member Name	*Group Name*
______________________ *Member Signature* ____/____/______ *Date*	______________________ *Employer Signature* ______________________ ____/____/______ *Title* *Date*

B. Transaction	Effective Date	Required Information
Addition	____/____/______	Who: Spouse Domestic Partner Civil Union Dependent(s) Reason: Open Enrollment Loss of Coverage Birth/Adoption Marriage Civil Union Partnership Other:______________________
Termination	____/____/______	Who: Employee Spouse/Partner Dependent(s) NY Young Adult Reason: Left Employer Discontinuation of Cobra Switched Plans Discontinuation of NY Young Adult (Age 26) Other:______________________
Change	____/____/______	Who: Last Name:__________ First Name:__________ Middle Initial ____ SSN __________ ____/____/______ Date of Birth ____/____/______ Effective Date Gender M F Reason: ______________________
COBRA or State Continuation	____/____/______	Who: Employee Spouse/Partner Dependent(s)* Reason: Left Employer Hours Reduction ____/____/______ Date of Event Other ______________________ *A New Member Enrollment Form is required for Loss of Dependent Status (Age 26), Divorce/Separation or Death of Subscriber.
Transfer	____/____/______	New Plan: ______________________ New Billing Group: ______________________ Enrolled in Medicare Part: A B D Reason: ______________________

To contact client services, please email us at **client360@paradigmhealthplans.org** or call us at **888.303.0034** available Monday through Friday, 8 a.m. to 7 p.m. (ET)