

**MEMBER NOTICE OF CHANGE FORM**

<p><b>Employer Name and Address:</b></p> <p><b>Change Effective Date:</b></p>	<p><b>MAIL THIS FORM TO:</b>  Patriot Healthcare  PO Box 2000  Exeter, NH 03833-2000  (800) 597-7728  FAX: 603-773-4410</p>
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**EMPLOYEE INFORMATION:**

Employee Name: \_\_\_\_\_ Employee SSN: \_\_\_\_\_

**CHANGE REQUEST:**

\_\_\_\_\_ Change Name To: \_\_\_\_\_

\_\_\_\_\_ Change Address To: \_\_\_\_\_

\_\_\_\_\_ Change Explanation: \_\_\_\_\_

\_\_\_\_\_ Add Employee: \_\_\_\_\_

\_\_\_\_\_ Delete Employee: \_\_\_\_\_

\_\_\_\_\_ Add Dependent(s): \_\_\_\_\_

\_\_\_\_\_ Delete Dependent(s): \_\_\_\_\_

	Name	Relationship	Date of Birth			Employer or Name of School If Child Is Over 19 Years
			MO	DAY	YR	
Spouse		Husband <input type="checkbox"/>				
SSN		Wife <input type="checkbox"/>				
Date of Marriage/ Civil Union		Partner <input type="checkbox"/>				
Child		Son <input type="checkbox"/>				
SSN		Daughter <input type="checkbox"/>				
Child		Son <input type="checkbox"/>				
SSN		Daughter <input type="checkbox"/>				
Child		Son <input type="checkbox"/>				
SSN		Daughter <input type="checkbox"/>				

I have reviewed this form and certify that the statements made herein are complete and true to the best of my knowledge and belief. I authorize any adjustments as required to facilitate the requested change(s).

EMPLOYEE'S SIGNATURE: \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

<p><b>FOR PATRIOT USE ONLY:</b> Effective Date of Change: _____</p>	<p>Group/Division Number: _____</p>
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