

Group Insurance Trust of the
California Society of
Certified Public Accountants

Subscriber Change Request
(For Existing Enrollments Only)

Office Use Only
Employer Code:

I. PLAN(S) CURRENTLY ENROLLED IN: Please check all that apply.

- ProtectPlus (PPO) Group Number: _____ Delta Dental
 Anthem Blue Cross HMO Group Number: _____ Vision Service Plan

II. SUBSCRIBER INFORMATION: Complete address portion ONLY if a recent change.

Current Last Name		First Name		MI	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Social Security No. - -	
Street Address (P.O. Box Not Acceptable)				Billing Address (If different or P.O. Box)			Home Phone No. ()	
City	State	Zip		City	State	Zip		Business Phone No. ()
Occupation		Employer Name			Spouse Social Security No. - -		Applicant/Spouse Maiden Name	

III. PLEASE CHANGE MY PLAN AS INDICATED:

- Add dependent(s) Delete dependent(s) If adding spouse/domestic partner, provide marriage date: _____
 Eligible dependents are your spouse/domestic partner and unmarried children within the agreement in your contract.
 Coverage granted to individuals listed here on shall be subject to all provisions and limitations of the agreement.
- Address Change
- Change my name as shown. My former name was:
- Anthem HMO – Please change my PMG/IPA as stated in Section IV.
- Other– Please specify:

IV. DEPENDENT INFORMATION: **Please note: Under the Medicare, Medicaid and State Children's Health Insurance Plan Extension Act of 2007 Social Security numbers for ALL family members are required. For additional information please refer to WWW.cms.hhs.gov/MandatoryInsRep.**

Add or Delete		Last Name	First Name	MI	Sex	Date of Birth	Full-Time Student	Disabled	Medicare	Social Security # (Required)	Anthem HMO Only	
											IPA Office No.	Primary Care Physician Code
	You				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> A <input type="checkbox"/> B			
<input type="checkbox"/> Add <input type="checkbox"/> Del	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> A <input type="checkbox"/> B			
<input type="checkbox"/> Add <input type="checkbox"/> Del	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> A <input type="checkbox"/> B			
<input type="checkbox"/> Add <input type="checkbox"/> Del	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> A <input type="checkbox"/> B			
<input type="checkbox"/> Add <input type="checkbox"/> Del	<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> A <input type="checkbox"/> B			

Subscriber Signature X _____ Date: _____

Please return the completed form to:
Or Fax to: (877) 237-4519

Banyan Administrators, LLC
1215 Manor Drive, Suite 200
Mechanicsburg, PA 17055