



Cultural Alliance of Greater Washington Healthcare Program

GROUP AUTHORIZATION FORM- CHANGE ENROLLMENT

MAY 1, 2008 – APRIL 30, 2009

<b>Group Name</b>		<b>Date</b>
<b>Contact Name</b>		<b>Telephone Number</b>

**PARTICIPANT ACTION**

Provide the name of each participant and select the action each would like to take concerning their coverage. If the participant elects to change coverage, do not mark what they currently have only mark what they would like to change their coverage to. Carrier applications are required for all coverage changes or new enrollments and must accompany this form. State the month and year the enrollment or termination is to become effective where is states Effective. Note: all terminations and enrollments become effective on the first of the month.

1	<b>Name</b>		<b>Social Security No.</b>		<b>Date of Birth</b>		
	Sex <input type="checkbox"/> M <input type="checkbox"/> F		City, State Zip				
<input type="checkbox"/> <b>New Enrollment</b> <input type="checkbox"/> <b>Terminate Coverage</b> <input type="checkbox"/> <b>Change Coverage</b> <b>Effective</b> /		<b>UnitedHealthcare</b>  <input type="checkbox"/> Basics Plan 152		<b>Denex Dental</b> <input type="checkbox"/> Single <input type="checkbox"/> Two-Party <input type="checkbox"/> Subscriber + Children <input type="checkbox"/> Family		<b>Advantica EyeCare</b> <input type="checkbox"/> Single <input type="checkbox"/> Two-Party <input type="checkbox"/> Family	

2	<b>Name</b>		<b>Social Security No.</b>		<b>Date of Birth</b>		
	Sex <input type="checkbox"/> M <input type="checkbox"/> F		City, State Zip				
<input type="checkbox"/> <b>New Enrollment</b> <input type="checkbox"/> <b>Terminate Coverage</b> <input type="checkbox"/> <b>Change Coverage</b> <b>Effective</b> /		<b>UnitedHealthcare</b>  <input type="checkbox"/> Basics Plan 152		<b>Denex Dental</b> <input type="checkbox"/> Single <input type="checkbox"/> Two-Party <input type="checkbox"/> Subscriber + Children <input type="checkbox"/> Family		<b>Advantica EyeCare</b> <input type="checkbox"/> Single <input type="checkbox"/> Two-Party <input type="checkbox"/> Family	

3	<b>Name</b>		<b>Social Security No.</b>		<b>Date of Birth</b>		
	Sex <input type="checkbox"/> M <input type="checkbox"/> F		City, State Zip				
<input type="checkbox"/> <b>New Enrollment</b> <input type="checkbox"/> <b>Terminate Coverage</b> <input type="checkbox"/> <b>Change Coverage</b> <b>Effective</b> /		<b>UnitedHealthcare</b>  <input type="checkbox"/> Basics Plan 152		<b>Denex Dental</b> <input type="checkbox"/> Single <input type="checkbox"/> Two-Party <input type="checkbox"/> Subscriber + Children <input type="checkbox"/> Family		<b>Advantica EyeCare</b> <input type="checkbox"/> Single <input type="checkbox"/> Double <input type="checkbox"/> Family	

4	<b>Name</b>		<b>Social Security No.</b>		<b>Date of Birth</b>		
	Sex <input type="checkbox"/> M <input type="checkbox"/> F		City, State Zip				
<input type="checkbox"/> <b>New Enrollment</b> <input type="checkbox"/> <b>Terminate Coverage</b> <input type="checkbox"/> <b>Change Coverage</b> <b>Effective</b> /		<b>UnitedHealthcare</b>  <input type="checkbox"/> Basics Plan 152		<b>Denex Dental</b> <input type="checkbox"/> Single <input type="checkbox"/> Two-Party <input type="checkbox"/> Subscriber + Children <input type="checkbox"/> Family		<b>Advantica EyeCare</b> <input type="checkbox"/> Single <input type="checkbox"/> Double <input type="checkbox"/> Family	

<b>Send this form and all necessary documents to:</b>			<b>Administrator Use Only</b>		050108
<b>Attention:</b> CAGW Healthcare <b>Mail:</b> 1436 U Street, NW, Suite 103, Washington, DC 20009 <b>Email:</b> tparrott@cultural-alliance.org <b>Fax:</b> 202-638-3388			<input type="checkbox"/> UHC Enroll <input type="checkbox"/> DNX Enroll <input type="checkbox"/> AEC Enroll		<input type="checkbox"/> New Program <input type="checkbox"/> Active Member <input type="checkbox"/> 90 Day Satisfied <input type="checkbox"/> Reinstatement