EmblemHealth®

Member/Dependent Change Form

MEMBER INFORMATION

Member Name		
Member BSC# (ID#)	EmblemHealth K ID#	Effective Date of Indicated Change (Required)

TYPE OF CHANGE

☐ Termination (Check box and sign.)	☐ Name Change (Go to section A.)	☐ Address Change (Go to section B.)	☐ Add or remove Dependant (Go to section C.)	☐ Reinstatement

A. CHANGE OF NAME

Last Name	First Name	M.I.
Address		Apt #
City	State	Zip Code / Phone Number

B. CHANGE OF ADDRESS

Address	Apt #
City / State / ZIP	

C. CHANGE DEPENDENTS – Spouse/domestic partner and dependent children (covered up to their 26th birthday).

☐ Add Dependents ☐ Remove Dependents ☐ Reinstate Dependents

Dependent (Last Name, First Name)	Date of Birth (DOB)	Social Security Number (optional)	Gender	Relationship to Member	Reason and Date of Occurrence
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Dependent (Last Name, First Name)	Date of Birth (DOB)	Social Security Number (optional)	Gender	Relationship to Member	Reason and Date of Occurrence
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In order for TWU Local 100 to complete the processing of your benefits, you must provide us with copies of the following documents:

- Marriage certificate for spouse
- Social Security cards for all dependents
- Birth certificate for all dependents
- Adoption/Legal Guardianship papers for dependent children

☐ I hereby apply to change my insurance coverage and/or records, as set forth herein.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any act material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed a thousand dollars and stated value of the claim for each violation.

Member Signature	Date

Return completed form to:

Transport Workers Union, Local 100
149 Pierrepont Street, Room 1.100
Brooklyn, N.Y 11201

PRINT RESET

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