PRINT NEATLY AND PRESS HARD

ADDRESS/NAME CHANGE FORM

Effective Date:

EMPLOYER

- ☐ City of Albuquerque
- ☐ Bernalillo County
- ☐ Town of Bernalillo
- ☐ Middle Rio Grande Conservancy District
- ☐ Sandoval County
- ☐ Village of Tijeras
- ☐ Village of Los Ranchos
- ☐ Village of Corrales
- ☐ Village of Cuba
- ☐ Village of Bosque Farms
- ☐ MRCOG
- ☐ Other__________

ACTION	**REASON FOR ACTION**
☐ **Address Change** ☐ **Name Change** ☐ **Other**__________	☐ **Moved** ☐ **Marriage** ☐ **Divorce** ☐ **Other**____________

Social Security No.	**Employee Name: First, M. I., Last:**	**Phone Numbers:** Home: / Work:

ADDRESS CHANGE

Current (New) Mailing Address:

City, State, ZIP:

Previous Mailing Address:

City, State, Zip:

NAME CHANGE (Must Include Proof Of Name Change)

Current (New) Name: First, M.I., Last

Previous Name: First, M.I., Last

Department:

Comments:

PLEASE MARK THE PLANS YOU PARTICIPATE IN:

- ☐ **Prebyterian Health Plan**
- ☐ **CIGNA Health Plan**
- ☐ **Delta Dental of NM**
- ☐ **United Concordia Dental**
- ☐ **Davis Vision Plan**
- ☐ **Other**____________

CERTIFICATION

I hereby submit the information on this form as application/change to health care coverage under a plan contracted by the City of Albuquerque. I have received and read descriptive literature of the health plan as it affects this application/change. I understand, accept and agree to abide by the terms and provisions of the city agreement in receiving services. I understand that membership may be automatically terminated if I have intentionally given any false information regarding myself and/or my dependents on this application. I authorize the health plan to disclose medical information concerning me or my dependents to authorized agencies when required under appropriate Federal/State legislation or regulation, and to obtain medical information from other appropriate agencies for the purpose of providing necessary health care/administrative services under the plan. I understand that the employer may change my premiums and/or benefits as part of the annual contract renewal process. I authorize my employer to deduct from my earnings the amount required to pay my share of health care premium fees.

Employee Signature X **Date**

Office Use Only

Employer Signature: ______________________________

Date:

Office Use Only

Orig. Benefits File *Yellow: Health Plan* *Pink: Dental Plan* *Goldenrod: Vision Plan*