



Arise Health Plan
P.O. Box 11625
Green Bay, WI 54307-1625
920-617-6330
Toll-free 1-888-711-1444 ext. 8330
Fax: 920-490-6928
BillingandEnrollment@wpsic.com

EMPLOYEE CHANGE FORM

PLEASE COMPLETE AND RETURN TO THE ADDRESS ABOVE.

Name of Employee: _____ Name of Employer: _____

Member #: _____ Group #: _____ Division# _____

CHANGE SUBMITTED

EFFECTIVE DATE REQUESTED: _____

Name Change
Former Name: _____

New Name: _____

Address Change
New Address: _____

Division/Class Change
New Division #: _____

Other Insurance Change
Do you or any family member currently have other health coverage? Yes, Single Yes, Family No

If yes to the above question, complete the following: Name of persons covered: _____

Employer Name: _____ Carrier Name: _____

Plan #: _____ Effective Date: _____

<input type="checkbox"/> Primary Care Physician Change	
Name of covered individual	New Primary Care Physician Name
_____	_____
_____	_____
_____	_____
_____	_____

This form becomes a part of your original application and is subject to the terms of the plan.

Signature _____ Print Name _____ Date _____