Change of Permanent Residence Address

Personal Information

*Member first name _____ Middle initial _____ *Last name _____

*Primary phone number _____ *Date of birth (mm/dd/yyyy) _____

*Medicare number or Network Health member ID _____

New Permanent Residence Street Address

*Street address (PO Box is not allowed) _____

*City_____ *County _____ *Zip code _____

***Date of move** (mm/dd/yyyy) _____

Mailing address if different from new permanent residence street address

Street address _____

City _____ State_____ Zip _____

Please read and sign below

By completing this address change, I agree to the following.

Network Health Medicare Advantage Plans serve a specific service area. I understand if my new permanent residence address is outside the area my Network Health Medicare Advantage Plan serves, I will be disenrolled from the plan and will need to find a new plan in my new area. Disenrollment will be effective the first of the month following receipt of notification of the move.

***Signature** _____ ***Date** (mm/dd/yyyy) _____

***If you are the authorized representative, you must sign above and provide the following information.**

Name _____ Relationship to member _____

Street address _____

City _____ State _____ Zip _____

Phone _____

Assisting agent

*Name _____

*Agent ID number _____

*Indicates a required field