COMMON GROUND
HEALTHCARE COOPERATIVE

Member Change Form

Submit Completed Form to:
Common Ground Healthcare Cooperative
PO Box 1630
Brookfield, WI 53008-1630

MEMBER ID # ______________________ GROUP NUMBER ______________________

I. Applicant Information

FIRST NAME	M.I.	LAST NAME	COUNTY YOU LIVE IN	DATE OF BIRTH

HOME ADDRESS – STREET	CITY	STATE	ZIP CODE

PRIMARY PHONE (include area code)	SECONDARY PHONE (include area code)	EMAIL ADDRESS

II. Reason for Application

A. UPDATE PERSONAL DATA - Choose all that apply.

○ Name Change - Indicate former name: ______________________
○ Address Change - Indicate updated address in Section I.
○ Telephone Number Change - Indicate updated number in Section I.
○ Date of Birth Correction - Change date to (mm/dd/yyyy) ______________ for (Name) ______________________
○ Social Security Number Correction - Change SSN to ______________ for (Name) ______________________

B. ADD DEPENDENT(S) - Update Section III below. Date of Event: ______________________

○ Birth
○ Adoption
○ Marriage
○ Domestic Partner (if provided by employer)
○ Loss of Coverage (Please attach proof of loss.)
○ Other: ______________________

C. REMOVE DEPENDENT(S) - Update Section III below. Date of Event: ______________________

○ Death
○ Divorce
○ Dependent no longer eligible
○ Domestic Partnership Terminated (if provided by employer)
○ Grandchild's parent turns 18
○ Other: ______________________

D. CHANGE BENEFIT PLAN DESIGN - Indicate current health plan, choose one and indicate the effective date. Update Section III below.

Current Benefit Plan Design: ______________________
New Benefit Plan Design: ______________________ Effective Date: ______________

E. CANCEL COVERAGE

○ Cancel my Current Coverage Reason: ______________________
Effective Date of Cancellation: ______________________

III. Dependent Information *- List all dpendents to be added or deleted.*

DEPENDENTS (Indicate last name ONLY if different than applicant.):

NAME (FIRST, MI, LAST)	SOCIAL SECURITY NUMBER	DISABILITY (Y/N)	DATE OF BIRTH (MM/DD/YYYY)	RELATIONSHIP	SEX (M/F)	TOBACCO USE* (Y/N)

*Not applicable if an employer group.

IV. Applicant's Authorization and Representation - *Read this section carefully, sign and date the application.*

I hereby apply for coverage on the basis of the statements and answers to the questions herein. I hereby represent all answers to be true to the best of my knowledge and to accurately represent the health of those persons applying for coverage and waiving coverage. I understand that these statements, answers and subsequent information I provide are the basis for my coverage. **I understand that if my application for new or additional coverage is accepted, that applicable coverage will not be effective until after I am notified of the Effective Date.**

I hereby authorize Common Ground Healthcare Cooperative (CGHC) to obtain from providers of services and hospitals, including those providers with whom CGHC contracts for service, the medical records, including those which relate to mental health and chemical dependency treatment, relating to me and my family members to the extent that those records are necessary for the administration of the CGHC contract, including for purposes of claims payment, case management, fraud investigation and quality of care review. A photocopy of this authorization shall be as valid as the original and remains in effect as long as continually insured by CGHC or until revoked.

I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMISSION OF RELEVANT INFORMATION TO COMMON GROUND HEALTHCARE COOPERATIVE IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIMS OR CANCELLATION OR RESCISSION OF COVERAGE.

SIGNATURE OF MEMBER **DATE SIGNED**

IMPORTANT - PLEASE READ CAREFULLY

Information provided on this application is solely for the purpose of administering the CGHC plan(s).

To enroll in Common Ground Healthcare Cooperative Plan:

- Answer every question, providing complete information about yourself and family members you want to cover. If information is missing or incomplete, your enrollment may be delayed and/or your coverage may be limited.

To submit your application:

- Please review all information for completeness and accuracy.
- Be sure to sign and date the application.

COMMON GROUND
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NOTICE OF NON-DISCRIMINATION AND AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

Common Ground Healthcare Cooperative (CGHC) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics). This means that CGHC does not exclude people or treat them differently because of race, color, national origin (including limited English proficiency and primary language), age, disability, sex (including pregnancy, sexual orientation, gender identity, and sex characteristics).

CGHC provides free aids and services to people with disabilities so they may communicate effectively with us such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, and other formats)

CGHC provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please contact the CGHC Civil Rights Coordinator.

If you believe that CGHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, sex (including pregnancy, sexual orientation, gender identity, or sex characteristics). You can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone.

CGHC Civil Rights Coordinator
Phone Number: 414.269.4684 (TTY: 711)
Fax Number: 262.754.9690
Email: CivilRights@CommonGroundHealthcare.org
Mail: PO Box 1630
Brookfield, WI 53008-1630

U.S. Department of Health and Human Services
Phone: 1.800.368.1019 (TDD: 1.800.537.7697)
Mail: 200 Independence Avenue SW,
Room 509F, HHH Building
Washington, DC 20201
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

French ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 1.877.514.2442 (TTY/TDD: 711)	**Spanish** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.877.514.2442 (TTY/TDD: 711)	**Chinese** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.877.514.2442 (TTY/TDD: 711)
Hmong LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.877.514.2442 (TTY/TDD: 711)	**Vietnamese** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.877.514.2442 (TTY/TDD: 711)	**Arabic** قيوغللا ةدعاسملا تامدخ ناف ،ةغللا ركذا ثدحتت تنك اذإ :ةظوحلم (TTY/TDD: 711) 1.877.514.2442 مقرب لصتا .ناجملاب كل رفاوتت
Pennsylvania Dutch Wann du [Deitsch] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.877.514.2442 (TTY/TDD: 711)	**Russian** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.877.514.2442 (телетайп: 711)	**Tagalog** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.877.514.2442 (TTY/TDD: 711).
German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.514.2442 (TTY/TDD: 711).	**Thai** ี ยน: ถา้ คุณพดภาษาไทยคุณสามารถใชบ้ รการชว่ ยเหลอื ทางภาษาไดฟ้ ร โทร 1.877.514.2442 (TTY/TDD: 711).	**Laotian** ໂປດຊາບ: ຖ້ າວ່ າ ທ່ າ ນເ ົ ວົ້ າພາສາ ລາວ, ການບໍລິການຊ່ ວຍເ ຼື ຫຼ ອດ້ ານພາສາ, ໂດຍ ໍ່ ໍບເສັ ຽຄ່ າ, ແມ່ ນມີພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ 1.877.514.2442 (TTY/TDD: 711)
Hindi धयान द : य द आप �हंद� बोलते ह तो आपके ि◌◌लए मु त म भाषा सहायता सेवाएं उपलबध ह । 1.877.514.2442. पर कॉल कर । (TTY/TDD:711)	**Polish** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.877.514.2442 (TTY/TDD: 711).	**Albanian** KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.877.514.2442. (TTY/TDD: 711)