Vision Plan of America

STATUS CHANGE FORM

INSTRUCTIONS FOR COMPLETING A STATUS CHANGE FORM

1. Please print all information clearly
2. General enrollee information must be filled out completely
3. Complete all applicable sections
4. Please sign & return completed form to **Vision Plan of America**

1. GENERAL ENROLLEE INFORMATION

MEMBER'S NAME (As on I.D. card): ______________________________

ADDRESS: ______________________________ APT#: __________

CITY: ______________ STATE: ______________ ZIP CODE: __________

TELEPHONE #: ______________ SOCIAL SECURITY #: ______________

MEMBER NUMBER (Include Group #): ______________________________

GROUP/EMPLOYER'S NAME: ______________________________

2. CHANGE OF DOCTOR REQUEST

CURRENT DOCTOR: ______________ FACILITY #: ______________

REASON FOR CHANGE: ______________________________

____

NEW DOCTOR: ______________ FACILITY #: ______________

3. OTHER CHANGES REQUESTED (PLEASE CHECK ONE OF THE FOLLOWING OPTIONS)

☐ NAME CHANGE ☐ ADDRESS CHANGE

NEW NAME: ______________________________

NEW ADDRESS: ______________________________ APT#: __________

CITY: ______________________________ ZIP CODE: __________

4. DEPENDENT(S) ADD/DELETE (PLEASE CHECK ONE OF THE FOLLOWING OPTIONS)

☐ ADD DEPENDENT(S) ☐ DELETE DEPENDENT(S)

	FIRST NAME	LAST NAME	DATE OF BIRTH
1.			
2.			
3.			
4.			

5. DELETE MEMBER(S)

	NAME	MEMBER #	SS#	AMOUNT
1.				
2.				
3.				
4.				
5.				
6.				
7.				

SIGNATURE (Required): ______________________________ **DATE:** ______________

VISION PLAN OF AMERICA

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