



FAMILY CHANGES FORM

NOTE: → *Your Social Security number is voluntary.*

INSTRUCTIONS AND GUIDELINES

If you have questions about the information or documents needed, go online to www.washingtonhealth.hca.wa.gov or call Washington Health at **1-800-660-9840**.

If you need additional copies of this form, you can print them from the Internet at www.washingtonhealth.hca.wa.gov, call Washington Health to request them, or photocopy this form.

Be sure to refer to the letter you received with this form for details on timing and other documents Washington Health needs from you.

SECTION ONE

CURRENT SUBSCRIBER

Social Security number (SSN)		Last name		First name		Middle initial	
House number	Street address	Apt./unit number	City	County	State	ZIP Code	
Mailing address (if different from street address)			City	County	State	ZIP Code	
Home phone number ()				Daytime phone number ()			
Email address					Do you prefer to be contacted by? <input type="checkbox"/> US Mail <input type="checkbox"/> Email		
U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No		Birth date / /		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Are you currently covered by Washington Health? <input type="checkbox"/> Yes <input type="checkbox"/> No				Applying for coverage for yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you: <input type="checkbox"/> Single <input type="checkbox"/> Legally married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced							
If married, separated, or divorced, give effective date / /							
Disabled and over 19? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, receiving Social Security Disability Benefits (SSDB) <input type="checkbox"/> Yes <input type="checkbox"/> No Entitlement date / /							
Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No				Receiving DSHS medical assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No							

(continued)

SECTION ONE (continued)

SPOUSE

If you are legally married and requesting coverage for your spouse, please provide their information.

Social Security number (SSN)	Last name	First name	Middle initial
Birth date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Applying for coverage for your spouse <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your spouse use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No		U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Disabled and over age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, receiving Social Security Disability Benefits (SSDB) <input type="checkbox"/> Yes <input type="checkbox"/> No Entitlement date / /			
Eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving DSHS medical assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your spouse pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	

DEPENDENTS

List legal dependents, including those age 18 and over, that you are requesting coverage for. If you have more than four, list on a separate sheet or copy this page.

1. Last name	First name	Middle initial	Social Security number
Birth date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Applying for coverage for this dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		Relationship to applicant	
Is dependent attending higher education out of state? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, send proof of registration.			
Disabled and over age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, receiving Social Security Disability Benefits (SSDB) <input type="checkbox"/> Yes <input type="checkbox"/> No Entitlement date / /			
Receiving DSHS medical assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Last name	First name	Middle initial	Social Security number
Birth date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Applying for coverage for this dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No		Relationship to applicant	
Is dependent attending higher education out of state? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, send proof of registration.			
Disabled and over age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, receiving Social Security Disability Benefits (SSDB) <input type="checkbox"/> Yes <input type="checkbox"/> No Entitlement date / /			
Receiving DSHS medical assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No			

(continued)

SECTION ONE (continued)**DEPENDENTS (continued)**

3. Last name		First name		Middle initial	Social Security number
Birth date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Applying for coverage for this dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No		Relationship to applicant	
U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is dependent attending higher education out of state? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, send proof of registration.					
Disabled and over age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, receiving Social Security Disability Benefits (SSDB) <input type="checkbox"/> Yes <input type="checkbox"/> No Entitlement date / /					
Receiving DSHS medical assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No					

4. Last name		First name		Middle initial	Social Security number
Birth date / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Applying for coverage for this dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No		Relationship to applicant	
U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is dependent attending higher education out of state? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, send proof of registration.					
Disabled and over age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, receiving Social Security Disability Benefits (SSDB) <input type="checkbox"/> Yes <input type="checkbox"/> No Entitlement date / /					
Receiving DSHS medical assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No					

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SECTION TWO

AGREEMENT (must be signed)

I understand that:

- By signing this form, I have authorized Washington Health to verify my eligibility information with other state or federal agencies or other third-party sources.
- I must report address changes and changes in my family within the timeframes shown in the Washington Health *Member Handbook*.
- Washington Health's deposit of my premium payment does not guarantee coverage. The payment will be refunded if I am determined ineligible for coverage.

I authorize my health plan or medical provider to give medical records for my children or myself to Washington Health for purposes of participation in Washington Health.

The information I have given in this form and the documents I'm enclosing are true, correct, and complete to the best of my knowledge. I understand that if I withhold information or give Washington Health false or misleading information, my family and I will lose coverage. If I have given false information, Washington Health may prosecute me for perjury or charge me for services received through fraud. If I am billed for past premiums or penalties but do not pay, the state may refer me for collection or bill my estate.

Must be signed by you and your spouse.

X _____
 Your signature Date Spouse's signature Date

Signatures of children age 18 and over who receive Washington Health coverage

X _____
 Your signature Date Signature Date

X _____
 Your signature Date Signature Date

Washington State law may require disclosure of any information you submit as a public record. Washington Health is administered by the Health Care Authority; our Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.



Please submit all required documentation.

Mail to: Washington Health, P.O. Box 42714, Olympia, WA 98504-2714

Fax to: 360-923-2910 or 360-923-2610