RMSCO INC.
Solutions-Driven Risk Management

TOWNSHIP OF IRVINGTON

CHANGE FORM

You have the right to request that we amend the Protected Health Information in the Designated Record Set we or our Business Associates maintain. We may decline your request if the information is not part of the Designated Record Set, we did not create the information, or we believe the information is complete and accurate. To exercise your right to request an amendment, please complete the following indicating the change requested.

Employee Name: _____ Social Security No: _____ - _____ - _____

Address: _____ Union: ☐

_____ Non-Union: ☐

Type Of Change:

☐ Transfer ☐ Reinstatement ☐ Add New Dependent (below) ☐ Other _____

☐ Address Change (above) date of change: ____/____/____

Complete the following when adding Dependents

☐ ***Spouse (Information MUST be completed)***

Last Name, First Name, MI	Sex	Date of Birth	Social Security Number
		____/____/____	_____-____-_____

MEDICARE ELIGIBLE? ☐ YES ☐ NO

"PART A" EFFECTIVE DATE: ____/____/____

"PART B" EFFECTIVE DATE: ____/____/____

"PART D" EFFECTIVE DATE: ____/____/____

IS SPOUSE EMPLOYED? ☐ YES ☐ NO

ENROLLED IN GROUP HEALTH PLAN? ☐ YES ☐ NO

TYPE OF COVERAGE: ☐ SINGLE ☐ FAMILY

☐ MEDICAL ☐ DENTAL ☐ PRESCRIPTION ☐ VISION

Name of Spouse's Employer _____ Street Address of Spouse's Employer _____ City, State, Zip code of Spouse's Employer _____

Phone Number of Spouse's Employer: (_____) _____-_____

☐ ***Child(ren)***

Last Name, First Name, MI	Sex	Date of Birth	Social Security Number	Disabled Y	Disabled N	Resides w/Employee Y	Resides w/Employee N
		____/____/____	_____-____-_____	☐	☐	☐	☐
		____/____/____	_____-____-_____	☐	☐	☐	☐
		____/____/____	_____-____-_____	☐	☐	☐	☐

Is there Other Coverage for Child(ren)? ☐ YES ☐ NO

If YES, Type of Coverage: ☐ Medical ☐ Dental ☐ Prescription ☐ Vision

Other Carrier Name _____ Other Carrier Street Address _____ Other Carrier City, State Zip Code _____

Phone Number of Other Carrier: (_____) _____-_____ Policy Number of Other Carrier: _____

I authorize payment of benefits to any doctor, physician or other provider for services that he/she may render to my family or me. I certify that all the above information is correct to the best of my knowledge. I desire to participate in the group medical program.

Under federal law it is a crime to knowingly and willfully make a false statement in connection the delivery or payment for health care benefits or services (18 USC SEC 1035). It is also a federal crime to attempt to defraud a health program or to knowingly and willfully steal or otherwise convert money from a health care fund (18 USC SEC 669) (18 USC SEC 1347). These crimes are punishable by a fine or imprisonment or both.

____/____/____ Date

_____ Employee Signature