Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

Employer Application Amendment

Applicant hereby applies for an Amendment to the Employer Group Application that is currently being reviewed / issued by Capital Health Plan. Upon acceptance of this amendment by CHP, it will become part of the True Employer Group Contract issued to the applicant named.

Applicant Information:

Group Number: _____

Group Name (From Current Application): _____

Requested Amendment (*Supporting Documentation may be required)**:**

Changes	**Additions**	**Deletions**
☐ Group Name*	☐ Employer Representative	☐ Employer Representative
☐ Physical Address*	☐ Additional Location*	☐ Other*
☐ Mailing Address*	☐ Other*	
☐ Other*		

Change Detail(s):

From: _____

To: _____

Addition(s):

I. Employer Representative _____ Title: _____
Phone: (____) _____-_____ Fax: (____) _____-_____ Email: _____
Type: ☐ Executive ☐ Administrative & Billing ☐ Administrative Only ☐ Billing Only

II. Additional Location: _____
Date of Acquisition: _____

III. Other: _____

Deletion(s):

Name: _____

I hereby authorize the changes to my Capital Health Plan (CHP) Employer Group contract. I understand and agree that the changes will not be effective until this application/ amendment is accepted by CHP. I represent that my statements on this application are true and compete and understand and agree that any misstatements may result in denial of benefits and/or termination of coverage of this Employer Group Policy.

_____ _____

Employer Representative Signature / Title Date