Stanislaus Foundation for Medical Care
Membership Change Request

HEALTH DENTAL VISION

Effective Date of Change		
Month	Day	Year

Group Name:				
Employee Last Name	First	M.I.	Birthdate / /	Soc. Sec. No.
Street Address	City	State	Zip	
☐**Change of Address**	New Street Address	City	State	Zip
☐**Change Last Name**	New Last Name		☐**Cancel Contract** ☐**Remove Member** **(dependent)**	
☐**Add Member** **(dependent)**	☐Spouse	☐Newborn Child	☐Adopted Child	☐Other, please specify

CHANGES TO DEPENDENTS COVERED UNDER CONTRACT- *Please indicate all members to change*

Add	Delete	Last Name	First	M.I.	Birthdate Mo	Birthdate Day	Birthdate Yr	Relationship	If new spouse date of marriage Mo	Day	Yr

For Office Use Only Date Entered / /	New Spouse's SS#:	
Initials:		signature date