



Change Form for UnitedHealthcare Benefit Services

Please complete this form in full and email to cac@uhcservices.com. We are unable to process incomplete forms.

A. Employer Information

Employer Name: _____ Phone: _____

Tax ID: _____ Employer Policy #: _____

B. Employer Address Change – Please provide if the employer’s primary business address has changed.

Street: _____ City: _____ State: _____ Zip: _____

C. Employer Tax ID Change – Please provide if the employer’s tax ID number has changed

New Tax ID: _____

D. Broker Information – Please provide if a Broker should be added to the employer’s account as a contact.

Broker Name: _____ Phone: _____

Email Address: _____ Website Access: Yes No

E. Change in Employer’s Benefit Administrator or Other Contacts

Health Insurance Portability and Accountability Act (HIPAA) privacy guidelines limit the persons to whom we may provide access to certain health information regarding your group. By completing this form, you are helping us prohibit access to protected personal and/ or group-level information by unauthorized users. By adding any individual designated to receive PHI, you are potentially granting the individual access to protected group information.

| Code | Primary Contact | Name of Contact | E-mail Address | Website Access |
|--|---|---------------------|------------------------|----------------|
| A= Add D = Delete U = Update Select one | Only one primary contact should be selected | First and Last Name | Complete Email Address | Yes / No |
| A D U | Yes No | | | Yes No |
| A D U | Yes No | | | Yes No |

Please provide the name and title of the person authorizing this update.

Name: _____ Title : _____