Sedera

Member Change Request Form

This form should be completed when an existing member experiences a life change event impacting dependent membership. Members can make changes to their personal information (address and phone) via their member portal. If a member has been terminated or wishes to terminate their Sedera membership. please email memberservices@sedera.com

Member Name: ______________________________________ Effective Date: ___________

Email and/or Mobile Number: ____

Life Change Event prompting change

- ❏ Marriage
- ❏ Birth/adoption of a child
- ❏ Acquisition of a foster child
- ❏ Loss of coverage
- ❏ Legal Separation / Divorce
- ❏ Death of spouse or dependent
- ❏ Other (please indicate here) ______________________

Dependent Changes

Name of dependent (First & Last)	**Date of Birth**	**Gender (M/F)**	**Relationship to Primary Member (Spouse, Child)**	**Add (A) or Delete (D) from membership**

If you are adding your spouse, the following information is REQUIRED:

Spouse email address: (must be unique)	
Spouse phone: (must be unique)	

Have any of these dependents used tobacco products within the past 12 months? **Yes** ▢ **No** ▢

Dependent(s) Addition

Health History

While member health status has no effect on eligibility for membership, there are limitations on the sharing of Needs that existed prior to the membership effective date. A Pre-existing Medical Condition, as previously defined, is subject to sharing limitations unless 36 months immediately prior to membership effective date has passed without any signs or symptoms of the condition, without any treatment needed, without any medication prescribed or taken, and without any suspicion by the patient or doctors that the condition is resurfacing. This applies whether or not the cause of the symptoms is unknown or misdiagnosed.

As part of the enrollment process, the following questions must be answered for each dependent being added to the membership.

Are any dependents currently taking any medications? **Yes** ▢ **No** ▢
If Yes, please list the dependent's name and their medications:

Has any member been hospitalized within the last 3 years? **Yes** ▢ **No** ▢
If yes, please list the member's name, date of hospitalization, and reason for hospitalization.

Has anyone dealt with any of the following medical conditions in the past 3 years?
ALL CONDITIONS MUST HAVE A YES/NO ANSWER. IF ONE IS LEFT BLANK, WE WILL RETURN THE FORM FOR COMPLETION BEFORE PROCESSING THE REQUEST.

Yes or No	Condition	Member's Name(s) and details
▢ ▢	Autoimmune disease or immunodeficiency	
▢ ▢	Cancer	
▢ ▢	Chronic or recurrent infections	
▢ ▢	Chronic pain conditions	
▢ ▢	Diabetes Type I or other endocrine disorders	
▢ ▢	Disorder of the blood	
▢ ▢	Gastrointestinal Disease or condition	
▢ ▢	Heart or vascular conditions of any kind	
▢ ▢	High Blood Pressure	
▢ ▢	Kidney, urinary conditions	

Yes or No	Condition	Member's Name(s) and details
▢ ▢	Neurologic/Brain Disorder	
▢ ▢	Obesity/overweight	
▢ ▢	Orthopedic diseases, including arthritis and back pain	
▢ ▢	Personality Disorder	
▢ ▢	Problems with ears, sinuses, vertigo, balance	
▢ ▢	Problems with eyes (other than needing corrective lenses)	
▢ ▢	Psychiatric Conditions	
▢ ▢	Skin diseases	
▢ ▢	Smoking/Addiction	
▢ ▢	Type 2 Diabetes	
▢ ▢	Other (please specify)	

NOTE: Needs requests for pre-existing conditions are subject to sharing restrictions per the Sedera Member Guidelines.

I indicate my understanding of and agreement to the restrictions and terms stated above.

Primary Member Signature: ______________________________________ Date: ___________

List Bill Entity Signature: ____ Date: ___________