UnitedHealthcare
A UnitedHealth Group Company

UnitedHealthcare
Attn: CA Small Group Sales Department
5701 Katella Avenue
MS: CA120-0517
Cypress, CA 90630

Group Information Change Form

Please complete form below and send to UnitedHealthcare via email at **CA_SB_GRP_Updates@uhc.com**. Once our office receives this form, the timeframe for updating the information is 3 to 5 business days.

Incomplete forms will be returned and the information will not be updated. **Please do not use this form for any eligibility additions, changes or terminations.**

**** Required fields***
Requestor Information: Please provide your contact information in order to confirm completion or contact you in case we need additional information.

*Name: _____ *Email: _____

Group Information:

*Group Name: _____

*Group Customer/Policy Number(s): _____

*Physical Address (on file): _____

*City, State, Zip: _____

*Group Phone: _____

Group Fax: _____

☐ **Change Group's Physical Address – Check box if physical address has changed and indicate new address below**

*Effective Date of Change: _____

*New Physical Address: _____

*City, State, Zip: _____

☐ **Change Group's Billing/Mailing Address - Check box if Billing/Mailing address has changed and indicate new address below**

*Effective Date of Change: _____

New Billing/Mailing Address: _____

City, State, Zip: _____

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Group Plan Administrator – check the appropriate box below

- ☐ **Update Plan Administrator Information**

Note: It is important to remove Plan Administrators that no longer work for your company. Keeping them on file gives them permission to access all group information and perform transactions on your groups account.

☐ **Remove Group Plan Administrator (check the box) provide name below**

Name: _____ Email: _____

☐ **Add a new Group Plan Administrator (check the box) provide name below**

Please print the name(s) and email address(es) of the new Plan Administrator(s)

Name: _____ Email: _____

Name: _____ Email: _____

☐ **Give the following Group Plan Administrator eServices access to billing, invoices, and eligibility. Check the box if you want the new Plan Administrator to be given online access to eServices.**

Please print the name(s) and email address(es) of the new plan administrator needing eServices access.

Name: _____ Email: _____

Name: _____ Email: _____

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

*Printed Name of Company Officer: _____

*Signature of Company Officer: _____

*Title of Company Officer: _____

*Date: _____

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 as Plan Administrator, you are potentially granting the individual access to protected group information. This form must be authorized by a Company Officer before any changes are made to the Plan Administrator information.