Member Information Update Form

elderplan®

Leading the way to great care.

Please print clearly.

NAME _____

ELDERPLAN MEMBER NUMBER _____ TODAY'S DATE _____

I would like to...

☐ **Confirm/update my address.**

My CURRENT/NEW address is:

_____ NY _____

STREET ADDRESS CITY STATE ZIP

_____

TELEPHONE E-MAIL ADDRESS

My OLD address is:

_____ NY _____

STREET ADDRESS CITY STATE ZIP

_____

TELEPHONE E-MAIL ADDRESS

_____

EFFECTIVE DATE:

☐ **Receive a new Elderplan member ID card.**

☐ **Change my Primary Care Physician (PCP).**

My NEW/REQUESTED PCP is:

_____

PRIMARY CARE PHYSICIAN NAME STREET ADDRESS STATE ZIP

_____ NY _____ _____

CITY STATE ZIP TELEPHONE

My OLD PCP is:

_____

PRIMARY CARE PHYSICIAN NAME STREET ADDRESS STATE ZIP

_____ NY _____ _____

CITY STATE ZIP TELEPHONE

Mail this form to: **Elderplan Member Service**
55 Water Street, 46th Floor
New York, NY 10041

Or fax to: **Elderplan Member Service**
(718) 630-2624

QUESTIONS?
Call Elderplan Member Service at **1-800-353-3765;**
TTY 1-800-662-1220 8 a.m.–8 p.m., 7 days a week.