

**MEMBER CHANGE FORM**

(Please see reverse side)

Please complete the summary and submit it with the applications and changes it reflects to:

**TUFTS HEALTH PLAN  
P.O. BOX 9186  
WATERTOWN, MA 02471-9186  
FAX 617-923-5898**

Submitted By:	Date Submitted:	
Name of Employer Group:	Group Number:	Telephone Number:

1. Name of Member (Last, First, MI)	2. Member No.	3. Plan Code	4. Action Code	5. Effective Date	6. Additional Information
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