UnitedHealthcare®
A UnitedHealth Group Company

United Healthcare
5701 Katella Ave
Cypress, California
M/S CA 120-0573

Group Information Update Form for CA

Please complete this form and mail to UnitedHealthcare; or **fax to: (877) 296-9853**, **Attn: Group Information Update.** Once this form is received in our office, 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

Group Information – Please indicate your group information.

*Group Name: _____

*Group Customer/Policy Number(s): _____

*Group Phone: _____

Group Fax: _____

***Effective date of change** _____

➢ **Please indicate below the address change you are requesting and check ALL that apply.**

☐ **Change Groups Mailing Address** – check if Mailing address needs to be updated and indicate new address below

New Mailing Address: _____

City, State, Zip: _____

☐ **Change Groups Physical Location Address** – check if Physical Location Address needs to be updated and indicate new address below

New Physical Address: _____

City, State, Zip: _____

☐ **Change Groups Billing Address -** check if Billing Address needs to be updated and indicate new address below

New Billing Address: _____

City, State, Zip: _____

➢ **Please indicate the new Plan Administrator Information below.**

☐ **Change Group Plan Administrator** – check the box to the left if looking to update the plan administrator.

Information to be Updated – Please print the name(s) and email address (es) of the Plan Administrator(s) and select 'Add' or 'Remove.'

Name: _____ Email: _____ ☐ Add ☐ Remove

Name: _____ Email: _____ ☐ Add ☐ Remove

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 _____

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.