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# Group Information Change and Online Authorization Form

**Please list all changes <u>after</u> the Authorized Agent Signature.**

Group Number: _____ Group Name: _____

**By signing below, I certify that:**

- I am **currently** an authorized agent of the group named above.
- I permit the below-named Online User to execute on my behalf submission of Online Employer transactions to UHA.
- I agree to accept full responsibility for the accuracy of the information submitted to UHA.
- I also certify that I will maintain on file all subscriber signatures and eligibility related information for transactions processed through UHA's Online Employer Portal, including a signed copy of the UHA enrollment form completed by the subscriber.
- I also understand that the appointment of the below-named Online User shall remain in effect until UHA receives written cancellation from me or my below-named Online User.

Authorized Agent's Name (Print): _____ Title:_____

Authorized Agent Signature: _____ Date: _____

***(Agent must <u>already</u> be a Group Administrator, Owner, or Company Officer)***

**<u>Group Administrator(s) – Add/Remove/Update</u>:** ☐ **Primary** **Effective Date:** _____

**Action Required (check one):** ☐ Add GA ☐ Remove GA ☐ Update GA Info ☐ Remove Online Access Only

**Name**: _____ Title: _____

Check if: ☐ Third Party Administrator OR ☐ Broker (*online access not available)

**Mailing Address**: _____

(Street, City, State, Zip Code)

**Phone: (____)** _____ **Fax: (____)** _____ **Email Address:** _____

**ONLINE ACCESS**: ☐ Yes ☐ No (**If No, do not complete below.**)

To the Entire Grp: ☐ Yes ☐ No, only Division Number: _____

Indicate Online Access Level: (Please check all that apply)

☐ Online Enrollment ☐ Online View Bill ☐ Online View Bill with Pay Bill*

***ONLY ONE USER MAY HAVE ONLINE VIEW BILL WITH PAY BILL.**

**<u>Additional Group Administrator(s) – Add/Remove/Update</u>:** ☐ **Secondary** **Effective Date:** _____

**Action Required (check one):** ☐ Add GA ☐ Remove GA ☐ Update GA Info ☐ Remove Online Access Only

**Name**: _____ Title: _____

Check if: ☐ Third Party Administrator OR ☐ Broker (*online access not available)

**Mailing Address**: _____

(Street, City, State, Zip Code)

**Phone: (____)** _____ **Fax: (____)** _____ **Email Address:** _____

**ONLINE ACCESS**: ☐ Yes ☐ No (**If No, do not complete below.**)

To the Entire Group: ☐ Yes ☐ No, only Division Number: _____

Indicate Online Access Level: (Please check all that apply)

☐ Online Enrollment ☐ Online View Bill ☐ Online View Bill with Pay Bill*

***ONLY ONE USER MAY HAVE ONLINE VIEW BILL WITH PAY BILL.**

Continue on page 2 for additional group changes.

**Additional Group Administrator(s) – Add/Remove/Update:** ☐ **Secondary** **Effective Date:** _____

**Action Required (check one):** ☐ Add GA ☐ Remove GA ☐ Update GA Info ☐ Remove Online Access Only

**Name**: _____ Title: _____
Check if: ☐ Third Party Administrator OR ☐ Broker (*online access not available)

**Mailing Address**: _____
(Street, City, State, Zip Code)

**Phone: (____)** _____ **Fax: (____)** _____ **Email Address:** _____

**ONLINE ACCESS**: ☐ Yes ☐ No (**If No, do not complete below.)**
To the Entire Group: ☐ Yes ☐ No, only Division Number: _____
Indicate Online Access Level: (Please check all that apply)
☐ Online Enrollment ☐ Online View Bill ☐ Online View Bill with Pay Bill*
***ONLY ONE USER MAY HAVE ONLINE VIEW BILL WITH PAY BILL.**

**Group Demographic Changes** **Effective Date of Changes:** _____

**Physical Address**: _____
(Street, City, State, Zip Code)

**Mailing Address**: _____
(Street, City, State, Zip Code)

**Phone: (____)** _____ **Fax: (____)** _____ **Email Address:** _____

**Please submit completed form to:** **UHA**
**Attn: Client Services Department**
**700 Bishop Street, Suite 300**
**Honolulu, HI 96813-4100**

**Fax: 1-866-796-3483**
**Email: clientservices@uhahealth.com**

**Please allow 4-6 business days for processing.**

**Internal UHA Use Only**

| First Reviewer/Submitting: | Second Reviewer/Processor: | Third Reviewer/Processor: |
|---|---|---|
| | | |