SELF-ATTESTATION CHANGE TO INCOME – EXISTING MEMBER

Select why you are completing this form (check all that apply):

☐ I am an existing member that has income **no longer received** from my previously reported income

☐ I am an existing member that has income that needs to be **added** to the income previously reported

☐ Other, (specify) _____

Please print clearly and fill out all applicable income amounts.

SECTION A: Member Information

Last name (Member)	First name (Member)	Member ID	Date of Birth

Last name (Spouse)	First name (Spouse)	Member ID	Date of Birth

SECTION B: Income Changes

Income to be Removed **The income reported below is for calendar year: _____**

If you are requesting to remove income that you no longer receive, please use the section below to itemize the gross amounts. If your reported income impacts your eligibility in the Prescription Advantage program and / or your membership category, you must provide supporting documentation. If documentation is not received, you will remain in your current membership category until you have sent supporting documentation. You may request a recalculation and provide the required documentation to remove that income.

Type (all applicable)	Gross Amount Member	Gross Amount Spouse
Employment Wages	$	$
Business / Self-Employment	$	$
3rd Party Sick Pay	$	$
IRA	$	$
Pension / Annuity	$	$
Unemployment	$	$
Alimony	$	$
Other (specify) _____	$	$
Other (specify) _____	$	$
Other (specify) _____	$	$

Total income to be removed = $_____

Income to be Added **The income reported below is for calendar year: _____**

If you are currently receiving Social Security wages, Veteran's Benefit (if applicable) or other income that was not listed on your federal tax returns at the time you applied to Prescription Advantage, you must indicate the gross amount of that income. If your income changes, you may request a recalculation and you may be required to provide the required documentation.

Type (all applicable)	Gross Amount Member	Gross Amount Spouse
Social Security Wages	$	$
Veteran's Benefits	$	S
Other (**specify**)_____	$	$

Total income to be added = $_____

SECTION C: Signature (Required)

I hereby certify, under the pains and penalties of perjury, that I have examined all the information on this form and the accompanying documentation and that it is true, complete, and correct to the best of my knowledge and belief. I further certify that any information I submit in the future related to this form and the accompanying documentation submitted will also be true, complete, and correct to the best of my knowledge and belief.

If you are acting on behalf of someone who is unable to complete this form because of a physical or mental condition, by signing this form, you are declaring that the information submitted, and any accompanying or supplemental information is true, complete, and correct to the best of your knowledge and belief. ****Note* - If you are a Healthcare Proxy/Power of Attorney, you must complete an Authorized Representative Form specifically for Prescription Advantage.***

Sign name (Member)..... Date .....

Sign name (Member Spouse, if applicable) ..... Date .....

☐ Check here if you are an Authorized Representative