

Subscriber Change Request

Blue Shield of California and Blue Shield of California Life & Health Insurance Company



All changes must be received within 31 days of the effective date of change.
This form cannot be used for primary care physician (PCP) changes – subscriber must call plan directly.

Employee identification – this section must be completed.

| | | |
|-------------------------------------|-----------------------------|----------|
| Subscriber ID number (from ID card) | Group number (from ID card) | |
| Social Security number | | |
| Work telephone | Home telephone | |
| Last name | First name | MI |
| Home street address | | |
| City | State | ZIP code |
| Group/employer name (if applicable) | E-mail address | |

Changes

Yes No Is this a change/correction of address?

Yes No Is the change/correction of address for a dependent?

If yes, please indicate dependent name and address change: _____

Requested effective date: _____

Correct my Social Security number to: _____ (Copy of Social Security card, a photo ID, a letter of verification from the Social Security office, and a written statement of why the employee is requesting the change must be attached.)

Transfer/add my health coverage to: HMO _____ PPO _____ POS _____ Active ChoiceSM* _____
 PPO Savings _____ Core FlexSM _____ Core Flex HMO _____

Transfer/add my specialty benefits coverage to: DHMO _____ DPPO _____ Core Flex Dental¹ _____ Core Flex Vision _____
 Vision _____ Life Insurance² _____

From Group No. _____ to Group No. _____ in my employer group. Note: If transferring coverage to HMO, POS, or DHMO, please complete Section A.

Correct/change name to: _____

Correct/change email address to: _____

Correct/change my date of birth from: _____ to: _____

Additional changes/comments: _____

Subscriber cancellation: I decline health plan coverage for myself (and dependents, if any) effective: _____

COBRA participant _____

Qualifying event _____

Is this a termination? If yes, list name(s): _____

Dependent coverage changes

Add dependent(s) – Complete section A – Requested effective date for additions: _____

Date of marriage if adding spouse: _____

Domestic partner – date of domestic partnership if adding: _____

If court ordered custody/coverage, enter date and attach copy of legal documents: _____

If adoption, enter date of adoption or date placed for adoption, and attach copy of legal documents: _____

Cancel dependent(s) – Complete section A – Requested effective date for deletions: _____

For Cancellation of Spouse or Domestic Partner: (select appropriate cancellation reason and provide date of event)

Divorce or termination of Domestic Partnership: Date: _____

Death: Date _____

Other reason (please specify) _____ Date: _____

For Cancellation of Dependent Children: (select appropriate cancellation reason and provide date of event)

Death: Date: _____

Other reason (please specify) _____ Date: _____

Please provide a copy of the HIPAA certificate if enrolling self and/or dependent(s) as a health plan participant during open enrollment (OE), or if you are adding dependent(s) to your coverage outside OE with a qualifying event.

Qualifying event: _____ Qualifying event date: _____

Note: Newborn/adopted children or children placed for adoption require a completed Subscriber Change Request to be submitted within 31 days from the date of birth/adoption/placement for adoption to be added to your coverage.

Please be sure to return this form as the second page contains your signature, which is necessary to process these changes.

Subscriber Change Request (continued)

Section A

Complete this section if adding/cancelling dependents.

Provide Personal Physician/Dental provider information, if the change pertains to HMO/POS/DHMO coverage.

Please check which benefit the change applies to:

| Add | Cancel | Self |
|---|--|--|
| <input type="checkbox"/> Dental | <input type="checkbox"/> Dental | Last name _____ First name _____ MI _____ Sex _____ |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Medical | |
| <input type="checkbox"/> Life ² | <input type="checkbox"/> Life ² | Social Security number: _____ Date of birth (mm/dd/yyyy) _____ |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Vision | |
| | | HMO/POS Personal Physician name Doctor's Name: _____ Provider No. _____ IPA/MG No. _____ |
| | | Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Dental HMO only dental provider Dental provider name: _____ Dental provider No. _____ |
| Add | Cancel | Spouse/domestic partner |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Dental | Last name _____ First name _____ MI _____ Sex _____ |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Medical | |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Vision | Social Security number: _____ Date of birth (mm/dd/yyyy) _____ |
| | | HMO/POS Personal Physician name Doctor's Name: _____ Provider No. _____ IPA/MG No. _____ |
| | | Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Dental HMO only dental provider Dental provider name: _____ Dental provider No. _____ |
| Add | Cancel | Child |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Dental | Last name _____ First name _____ MI _____ Sex _____ |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Medical | |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Vision | Social Security number: _____ Date of birth (mm/dd/yyyy) _____ |
| Is this dependent a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No | | HMO/POS Personal Physician name Doctor's Name: _____ Provider No. _____ IPA/MG No. _____ |
| | | Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Dental HMO only dental provider Dental provider name: _____ Dental provider No. _____ |
| Add | Cancel | Child |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Dental | Last name _____ First name _____ MI _____ Sex _____ |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Medical | |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Vision | Social Security number: _____ Date of birth (mm/dd/yyyy) _____ |
| Is this dependent a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No | | HMO/POS Personal Physician name Doctor's Name: _____ Provider No. _____ IPA/MG No. _____ |
| | | Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Dental HMO only dental provider Dental provider name: _____ Dental provider No. _____ |
| Add | Cancel | Child |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Dental | Last name _____ First name _____ MI _____ Sex _____ |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Medical | |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Vision | Social Security number: _____ Date of birth (mm/dd/yyyy) _____ |
| Is this dependent a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No | | HMO/POS Personal Physician name Doctor's Name: _____ Provider No. _____ IPA/MG No. _____ |
| | | Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Dental HMO only dental provider Dental provider name: _____ Dental provider No. _____ |

All information I have provided on this form is accurate and complete. I understand that this form, along with any prior enrollment form, the Evidence of Coverage/Certificate of Insurance and Health Service Agreement/policy, and any endorsements and attachments thereto, collectively constitutes the entire agreement for coverage.

Employee signature _____ Date _____

If faxing this form, keep this document for your files.

Blue Shield of California/Blue Shield Life protects the confidentiality and privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, and Social Security number. We will not disclose this information, except as permitted by law.

Please be sure to return this form as the second page contains your signature, which is necessary to process these changes.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

1 This dental package is only available when employer purchases the Core Flex medical package. The Core Flex Dental package is not available with Core Flex HMO, with other Blue Shield medical plans, or without a Blue Shield medical plan.

2 Evidence of Insurability form may be required.