

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)	
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 Choice^{SM*} _____
 PPO Savings _____ Core FlexSM _____

Transfer/add my specialty benefits coverage to: DHMO _____ DPPO _____ Life insurance[†]
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 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): _____

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). † Evidence of Insurability form may be required.

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: ___/___/_____

Employer groups: If applicable, please have employee 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 employee is adding dependent(s) to their 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 the employee's 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"/> Medical <input type="checkbox"/> Life	<input type="checkbox"/> Dental <input type="checkbox"/> Medical <input type="checkbox"/> Life	Last name _____ First name _____ MI _____ Sex _____ Social Security number: _____ Date of birth (Mo./Day/Yr.) ____/____/____ HMO/POS Personal Physician name Doctor's Name: _____ Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Provider No. _____ Dental HMO only dental provider IPA/MG No. _____ Dental provider name: _____ Dental provider No. _____
Add	Cancel	Spouse/domestic partner
<input type="checkbox"/> Dental <input type="checkbox"/> Medical	<input type="checkbox"/> Dental <input type="checkbox"/> Medical	Last name _____ First name _____ MI _____ Sex _____ Social Security number: _____ Date of birth (Mo./Day/Yr.) ____/____/____ HMO/POS Personal Physician name Doctor's Name: _____ Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Provider No. _____ Dental HMO only dental provider IPA/MG No. _____ Dental provider name: _____ Dental provider No. _____
Add	Cancel	Child
<input type="checkbox"/> Dental <input type="checkbox"/> Medical	<input type="checkbox"/> Dental <input type="checkbox"/> Medical	Last name _____ First name _____ MI _____ Sex _____ Social Security number: _____ Date of birth (Mo./Day/Yr.) ____/____/____ Is this dependent a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No HMO/POS Personal Physician name Doctor's Name: _____ Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Provider No. _____ Dental HMO only dental provider IPA/MG No. _____ Dental provider name: _____ Dental provider No. _____
Add	Cancel	Child
<input type="checkbox"/> Dental <input type="checkbox"/> Medical	<input type="checkbox"/> Dental <input type="checkbox"/> Medical	Last name _____ First name _____ MI _____ Sex _____ Social Security number: _____ Date of birth (Mo./Day/Yr.) ____/____/____ Is this dependent a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No HMO/POS Personal Physician name Doctor's Name: _____ Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Provider No. _____ Dental HMO only dental provider IPA/MG No. _____ Dental provider name: _____ Dental provider No. _____
Add	Cancel	Child
<input type="checkbox"/> Dental <input type="checkbox"/> Medical	<input type="checkbox"/> Dental <input type="checkbox"/> Medical	Last name _____ First name _____ MI _____ Sex _____ Social Security number: _____ Date of birth (Mo./Day/Yr.) ____/____/____ Is this dependent a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No HMO/POS Personal Physician name Doctor's Name: _____ Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Provider No. _____ Dental HMO only dental provider IPA/MG No. _____ Dental provider name: _____ Dental provider No. _____

For group coverage employer verification:

Employer must sign for any subscriber name change, subscriber cancellation, dependent addition/deletion, or transfer to a different group number or section/billing unit.

Employer signature _____ Date ____/____/____

Employee signature _____ Date ____/____/____

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.

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.