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 Choice®* ______ ☐ Shield Savings Plus ______ ☐ Core Flex Optimum______ ☐ Core Flex HMO ______ ☐ Core Flex Value ______

☐ Transfer/add my specialty benefits coverage to: ☐ DHMO ______ ☐ DPPO ______ ☐ Core Flex Dental[1] ______ ☐ Core Flex Vision ______ ☐ Vision ______ ☐ Life Insurance[2]

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) who are age 19 or older 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			
☐ Dental ☐ Medical ☐ Life² ☐ Vision	☐ Dental ☐ Medical ☐ Life² ☐ Vision	Last name	First name	MI	Sex
		Social Security number:	Date of birth (mm/dd/yyyy) ______		
		HMO/POS Personal Physician name Doctor's Name: ______ Provider No. ______ IPA/MG No. ______	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: ______ Dental provider No. ______	

Add	Cancel	Spouse/domestic partner			
☐ Dental ☐ Medical ☐ Vision	☐ Dental ☐ Medical ☐ Vision	Last name	First name	MI	Sex
		Social Security number:	Date of birth (mm/dd/yyyy) ______		
		HMO/POS Personal Physician name Doctor's Name: ______ Provider No. ______ IPA/MG No. ______	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: ______ Dental provider No. ______	

Add	Cancel	Child			
☐ Dental ☐ Medical ☐ Vision	☐ Dental ☐ Medical ☐ Vision	Last name	First name	MI	Sex
		Social Security number:	Date of birth (mm/dd/yyyy) ______		
		HMO/POS Personal Physician name Doctor's Name: ______ Provider No. ______ IPA/MG No. ______	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: ______ Dental provider No. ______	

Add	Cancel	Child			
☐ Dental ☐ Medical ☐ Vision	☐ Dental ☐ Medical ☐ Vision	Last name	First name	MI	Sex
		Social Security number:	Date of birth (mm/dd/yyyy) ______		
		HMO/POS Personal Physician name Doctor's Name: ______ Provider No. ______ IPA/MG No. ______	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: ______ Dental provider No. ______	

Add	Cancel	Child			
☐ Dental ☐ Medical ☐ Vision	☐ Dental ☐ Medical ☐ Vision	Last name	First name	MI	Sex
		Social Security number:	Date of birth (mm/dd/yyyy) ______		
		HMO/POS Personal Physician name Doctor's Name: ______ Provider No. ______ IPA/MG No. ______	Current patient? ☐ Yes ☐ 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.