blue california

Subscriber Change Request

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

All changes must be received within 31 days of the effective date of change. This form cannot be used for primary care physician changes – subscriber must call the Member Services phone number on the back of their ID card.

Employee identification – this section must be completed.

Subscriber ID number (from ID card)	Social Security number	Group number (from ID card)
Cell phone number	Landline phone number	
Last name	First name	MI
Home street address – City	State	ZIP code
Group/employer name (if applicable)	Email address	

Changes

☐ Yes ☐ No Is this a change/correction of address?

☐ Yes ☐ No Is the change/correction of address for a dependent? (**Note**: Dependent's address will default to subscriber's address if 'No' is indicated here.)

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

☐ 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.)

☐ This is a change made during open enrollment.

☐ Transfer/add my health coverage to: ☐ Access+ HMO® _____ ☐ Access+ HMO® SaveNet℠ _____ ☐ Local Access+ HMO _____
☐ Trio HMO _____ ☐ Full PPO _____ ☐ Active Choice®* _____ ☐ Active Choice® Plus _____
☐ Active Choice® Classic_____ ☐ Full PPO Savings _____ ☐ Tandem PPO _____ ☐ Tandem PPO Savings _____
☐ Added Advantage POS℠ _____

☐ Transfer my ABHP benefits coverage to:

For Access+ HMO®: ☐ HRA ☐ HIA ☐ FSA
For Access+HMO® SaveNet℠: ☐ HRA ☐ HIA ☐ FSA
For Local Access+ HMO: ☐ HRA ☐ HIA ☐ FSA
For Trio HMO: ☐ HRA ☐ HIA ☐ FSA
For Full PPO: ☐ HRA ☐ HIA ☐ FSA
For Active Choice®: ☐ HRA ☐ HIA ☐ FSA
For Active Choice® Plus: ☐ HRA ☐ HIA ☐ FSA
For Active Choice® Classic: ☐ HRA ☐ HIA ☐ FSA
For Full PPO Savings: ☐ HSA ☐ HRA ☐ HIA ☐ FSA ☐ LPFSA
For Tandem PPO: ☐ HRA ☐ HIA ☐ FSA
For Tandem PPO Savings: ☐ HSA ☐ HRA ☐ HIA ☐ FSA ☐ LPFSA
Added Advantage POS℠: ☐ HRA ☐ HIA ☐ FSA

☐ Transfer my specialty benefits coverage to: ☐ DHMO _____ ☐ DPPO _____ ☐ DINO _____
From Group # _____ to Group # _____ in my employer group. Note: If transferring coverage to HMO, POS, or DHMO, please complete Section A.

☐ Change the amount of Basic Group Term Life or Supplemental Life and Supplemental AD&D insurance coverage: (provide prior coverage amount and new coverage amount)
Prior amount of Basic Group Term Life coverage: $ _____ New amount of coverage: $ _____
Prior amount of Supplemental Life and/or Supplemental AD&D coverage: $ _____ New amount of coverage: $ _____
(If Supplemental AD&D coverage is purchased, it is always in the same amount as the Supplemental Life coverage)

☐ 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: _____
☐ Effective date of above qualifying event: _____
☐ Is this a termination? If yes, list name(s): _____

Spouse/domestic partner/dependent child(ren) coverage changes

Add spouse/domestic partner/dependent child(ren) – 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: _____
☐ Disabled dependent over the age of 25 (Attach a 'Declaration of disability for over age dependent child' form (C3674) or confirmation that your current health carrier is providing coverage for this disabled dependent.)

☐ Change the Supplemental Group Term Life and AD&D insurance coverage amount of the spouse or domestic partner: (provide prior coverage amount and new coverage amount) Prior amount of coverage: $_____ New amount of coverage: $_____

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: _____

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 third page contains your signature, which is necessary to process these changes.

Section A

Complete this section if adding/canceling coverage for yourself or your dependents. Provide primary care physician/dental provider information if the change pertains to HMO/POS/DHMO coverage. Please fill in which benefit the change applies to:

Add	Cancel	Self
☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Basic Life/ AD&D** ☐ **Dep. Life** ☐ **Supp. Life†** ☐ **Supp. Life/ AD&D†**	☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Basic Life/ AD&D** ☐ **Dep. Life** ☐ **Supp. Life** ☐ **Supp. Life/ AD&D**	Last name / First name / MI / Sex
		Please tell us about yourself. How would you describe your race or ethnicity? These questions are optional and are only used to help ensure all members have the same access to the highest quality of care.
		1. Are you of Hispanic or Latino origin? ☐ Yes ☐ No ☐ Unknown ☐ Declined 2. If yes, please select one: ☐ Cuban ☐ Guatemalan ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Salvadoran ☐ 2 or more Ethnicities ☐ Other Hispanic, Latino, Spanish: _____ 3. Which race(s) do you identify with? (select one) ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White ☐ 2 or more Races ☐ Other ☐ Unknown ☐ Declined
		Social Security number: / Date of birth (mm/dd/yyyy) _____
		Language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Persian ☐ Other _____
		Job title/classification / Annual earnings (not including bonuses, overtime, etc.) $ _____
		If adding Basic Life and AD&D insurance please indicate amount requested: $ _____ If adding Supp. Life and/or Supp. AD&D insurance please indicate amount requested: $ _____ If adding Dependent Life, please indicate amount requested: $ _____ (Note: Spouse and all children will be covered for the same benefit amount)
		HMO/POS primary care physician name Doctor's name: _____ Provider #: _____ IPA/MG #: _____ Current patient? ☐ Yes ☐ No **Dental HMO only dental provider** Dental provider name: _____ Dental provider #: _____

Add	Cancel	Spouse/domestic partner
☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life†** ☐ **Supp. Life/ AD&D†**	☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life** ☐ **Supp. Life/ AD&D**	Last name / First name / MI / Sex
		What race or ethnicity does this member identify with:
		Social Security number: / Date of birth (mm/dd/yyyy) _____
		If adding Supp. Life and/or Supp. AD&D insurance please indicate amount requested: $ _____
		HMO/POS primary care physician name Doctor's name: _____ Provider #: _____ IPA/MG #: _____ Current patient? ☐ Yes ☐ No **Dental HMO only dental provider** Dental provider name: _____ Dental provider #: _____

Add	Cancel	Child			
☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life†** ☐ **Supp. Life/ AD&D†**	☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life** ☐ **Supp. Life/ AD&D**	Last name	First name	MI	Sex
		What race or ethnicity does this member identify with:			
		Social Security number:		Date of birth (mm/dd/yyyy) _____	
		If adding Supp. Life and/or Supp AD&D insurance please indicate amount: $ _____ ($5,000 or $10,000) (Note: All children will be covered for the same amount for Supplemental Life and Supplemental AD&D coverage.)			
		If adding Dependent Life, please indicate amount requested: $ _____ (Note: Spouse and all children will be covered for the same benefit amount)			
		HMO/POS primary care physician name Doctor's name: _____ Provider #: _____ IPA/MG #: _____	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: _____ Dental provider #: _____	

Add	Cancel	Child			
☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life†** ☐ **Supp. Life/ AD&D†**	☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life** ☐ **Supp. Life/ AD&D**	Last name	First name	MI	Sex
		What race or ethnicity does this member identify with:			
		Social Security number:		Date of birth (mm/dd/yyyy) _____	
		If adding Supp. Life and/or Supp AD&D insurance please indicate amount: $ _____ ($5,000 or $10,000) (Note: All children will be covered for the same amount for Supplemental Life and Supplemental AD&D coverage.)			
		If adding Dependent Life, please indicate amount requested: $ _____ (Note: Spouse and all children will be covered for the same benefit amount)			
		HMO/POS primary care physician name Doctor's name: _____ Provider #: _____ IPA/MG #: _____	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: _____ Dental provider No. _____	

Add	Cancel	Child			
☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life†** ☐ **Supp. Life/ AD&D†**	☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life** ☐ **Supp. Life/ AD&D**	Last name	First name	MI	Sex
		What race or ethnicity does this member identify with:			
		Social Security number:		Date of birth (mm/dd/yyyy) _____	
		If adding Supp. Life and/or Supp AD&D insurance please indicate amount: $ _____ ($5,000 or $10,000) (Note: All children will be covered for the same amount for Supplemental Life and Supplemental AD&D coverage.)			
		If adding Dependent Life, please indicate amount requested: $ _____ (Note: Spouse and all children will be covered for the same benefit amount)			
		HMO/POS primary care physician name Doctor's name: _____ Provider #: _____ IPA/MG #: _____	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: _____ Dental provider #: _____	

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 information. Personal and health information which may individually identifiable information, such as your name, address, telephone number, Social Security number, and health information. We will not disclose this information, except as permitted by law.

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

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

† Evidence of Insurability form is required for Supplemental Life. Approval must be received for any added Supplemental Life coverage. The effective date of coverage will be the first of the month following approval.