

Small Group 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. Please refer to the phone number on the back of your ID card.

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			Apt #
City		State	ZIP code
Group/employer name:		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/change email address to: _____

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 coverage to: HMO _____ PPO _____ POS _____ Active ChoiceSM _____ Shield SavingsSM _____
 DHMO _____ DPPO _____ Vision _____ Life Insurance¹ _____

From Group No. _____ to Group No. _____ in my employer group.

Note: If transferring coverage to HMO, POS, or DHMO coverage, please complete Section A on page 2.

Correct/change name to: _____

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

Additional changes/comments: _____

COBRA participant

Qualifying event and date _____

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 ___/___/_____

Newborn child – date of birth: ___/___/_____

If court ordered custody, please give date and attach copy of legal documents: ___/___/_____

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

Enroll/reenroll dependent child – If reenrollment, date dependent was last covered on this group plan: ___/___/_____

Cancel dependent(s)

Requested effective date for deletions: ___/___/_____

Date of divorce if canceling spouse: ___/___/_____

Domestic partner – date of domestic partnership termination: ___/___/_____

Other _____

PLEASE NOTE: A completed Refusal of Coverage (C19927) is required for dependent's cancelling coverage but remaining eligible.

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 to be added to your coverage.

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

1 Evidence of Insurability form may be required.

Please be sure to return all pages of this form as the second page contains your signature which is necessary to process these changes. Fax requests to (209) 367-6475. Missing information may delay processing.

Subscriber Change Request (continued)

Section A

Please check which benefit the change applies to: **M = Medical plan, D = Dental plan, V = Vision Plan, or L = Life Insurance**

Complete this section if adding/canceling dependents or if transferring to HMO, POS, and/or dental HMO plan(s).

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

Add <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	Cancel <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	Self			Social Security number		
		Last name		First name		MI	Sex
		Date of birth (Mo./Day/Yr.)		____/____/____			
		HMO/POS Personal Physician name Doctor's Name: _____ Provider No. _____ IPA/MG No. _____			Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental HMO only dental provider Dental provider name: _____ Dental provider No. _____
Add <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	Cancel <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	Spouse/domestic partner			Social Security number		
		Last name		First name		MI	Sex
		Date of birth (Mo./Day/Yr.)		____/____/____			
		HMO/POS Personal Physician name Doctor's Name: _____ Provider No. _____ IPA/MG No. _____			Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental HMO only dental provider Dental provider name: _____ Dental provider No. _____
Add <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	Cancel <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	Child			Social Security number		
		Last name		First name		MI	Sex
		Date of birth (Mo./Day/Yr.)		____/____/____			
		HMO/POS Personal Physician name Doctor's Name: _____ Provider No. _____ IPA/MG No. _____			Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental HMO only dental provider Dental provider name: _____ Dental provider No. _____
Add <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	Cancel <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	Child			Social Security number		
		Last name		First name		MI	Sex
		Date of birth (Mo./Day/Yr.)		____/____/____			
		HMO/POS Personal Physician name Doctor's Name: _____ Provider No. _____ IPA/MG No. _____			Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental HMO only dental provider Dental provider name: _____ Dental provider No. _____
Add <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	Cancel <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	Child			Social Security number		
		Last name		First name		MI	Sex
		Date of birth (Mo./Day/Yr.)		____/____/____			
		HMO/POS Personal Physician name Doctor's Name: _____ Provider No. _____ IPA/MG No. _____			Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> 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.