blue of california

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 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)
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? (**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 _____ ☐ POS _____
☐ Shield PPO _____ ☐ Shield Spectrum PPO _____ ☐ Active Choice* _____ ☐ Shield PPO Savings Plus _____

☐ Transfer my ABHP benefits coverage to:
For Access+ HMO: ☐ HRA ☐ HIA ☐ FSA
For Local Access+ HMO: ☐ HRA ☐ HIA ☐ FSA
For Shield PPO and Shield Spectrum PPO ☐ HRA ☐ HIA ☐ FSA
For Shield PPO Savings Plus: ☐ HRA ☐ HIA ☐ FSA ☐ HSA ☐ LFSA

For 51-100 Small Group Transition plans, transfer/add my health coverage to: ☐ HMO ☐ PPO ☐ PPO for HSA

☐ Transfer my ABHP benefits coverage to:
For HMO: ☐ HRA ☐ HIA ☐ FSA
For PPO: ☐ HRA ☐ HIA ☐ FSA
For Shield PPO Savings Plus for HSA: ☐ HRA ☐ HIA ☐ FSA ☐ LFSA

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

☐ Change the Basic Group Term Life/Supplemental Life and AD&D insurance coverage: (provide prior coverage amount and new coverage amount)
Prior amount of coverage: $_____ New amount of 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.)

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☐ 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: _____

Please provide a copy of the HIPAA certificate if enrolling self and/or dependent(s) that are over age 25 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.

Section A

Complete this section if adding/canceling coverage for yourself or your dependents. Provide Personal 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** ☐ **Life‡** ☐ **Supp. Life‡**	☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Life** ☐ **Supp. Life**	Last name	First name	MI	Sex
		Social Security number:		Date of birth (mm/dd/yyyy) _____	
		If adding Basic life/AD&D insurance please indicate amount: $_____ If adding Supp. life insurance please indicate amount: $_____			
		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** ☐ **Life‡** ☐ **Supp. Life‡**	☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Life** ☐ **Supp. Life**	Last name	First name	MI	Sex
		Social Security number:		Date of birth (mm/dd/yyyy) _____	
		If adding Basic life/AD&D insurance please indicate amount: $_____ If adding Supp. life insurance please indicate amount: $_____			
		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** ☐ **Life‡** ☐ **Supp. Life‡**	☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Life** ☐ **Supp. Life**	Last name	First name	MI	Sex
		Social Security number:		Date of birth (mm/dd/yyyy) _____	
		If adding Supp. Life insurance please indicate amount: $_____($5,000 or $10,000) (Note: all children will be covered for the same amount.)			
		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. _____	

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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).
‡ Evidence of Insurability form may be required.