

# 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.)

# Subscriber Change Request (continued)

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												
<input type="checkbox"/> Dental	<input type="checkbox"/> Dental	Last name _____ First name _____ MI _____ Sex _____												
<input type="checkbox"/> Medical	<input type="checkbox"/> Medical													
<input type="checkbox"/> Vision	<input type="checkbox"/> Vision	Social Security number: _____ Date of birth (mm/dd/yyyy) _____												
<input type="checkbox"/> Life <sup>†</sup>	<input type="checkbox"/> Life	If adding Basic life/AD&D insurance please indicate amount: \$ _____												
<input type="checkbox"/> Supp. Life <sup>†</sup>	<input type="checkbox"/> Supp. Life	If adding Supp. life insurance please indicate amount: \$ _____												
		<table border="1"> <tr> <th>HMO/POS Personal Physician name</th> <th>Current patient?</th> <th>Dental HMO only dental provider</th> </tr> <tr> <td>Doctor's name: _____</td> <td><input type="checkbox"/> Yes</td> <td>Dental provider name: _____</td> </tr> <tr> <td>Provider No. _____</td> <td><input type="checkbox"/> No</td> <td>Dental provider No. _____</td> </tr> <tr> <td>IPA/MG No. _____</td> <td></td> <td></td> </tr> </table>	HMO/POS Personal Physician name	Current patient?	Dental HMO only dental provider	Doctor's name: _____	<input type="checkbox"/> Yes	Dental provider name: _____	Provider No. _____	<input type="checkbox"/> No	Dental provider No. _____	IPA/MG No. _____		
HMO/POS Personal Physician name	Current patient?	Dental HMO only dental provider												
Doctor's name: _____	<input type="checkbox"/> Yes	Dental provider name: _____												
Provider No. _____	<input type="checkbox"/> No	Dental provider No. _____												
IPA/MG No. _____														
Add	Cancel	Spouse/domestic partner												
<input type="checkbox"/> Dental	<input type="checkbox"/> Dental	Last name _____ First name _____ MI _____ Sex _____												
<input type="checkbox"/> Medical	<input type="checkbox"/> Medical													
<input type="checkbox"/> Vision	<input type="checkbox"/> Vision	Social Security number: _____ Date of birth (mm/dd/yyyy) _____												
<input type="checkbox"/> Life <sup>†</sup>	<input type="checkbox"/> Life	If adding Basic life/AD&D insurance please indicate amount: \$ _____												
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Doctor's name: _____	<input type="checkbox"/> Yes	Dental provider name: _____												
Provider No. _____	<input type="checkbox"/> No	Dental provider No. _____												
IPA/MG No. _____														
Add	Cancel	Child												
<input type="checkbox"/> Dental	<input type="checkbox"/> Dental	Last name _____ First name _____ MI _____ Sex _____												
<input type="checkbox"/> Medical	<input type="checkbox"/> Medical													
<input type="checkbox"/> Vision	<input type="checkbox"/> Vision	Social Security number: _____ Date of birth (mm/dd/yyyy) _____												
<input type="checkbox"/> Life <sup>†</sup>	<input type="checkbox"/> Life	If adding Supp. Life insurance please indicate amount: \$ _____ (\$5,000 or \$10,000)												
<input type="checkbox"/> Supp. Life <sup>†</sup>	<input type="checkbox"/> Supp. Life	(Note: all children will be covered for the same amount.)												
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HMO/POS Personal Physician name	Current patient?	Dental HMO only dental provider												
Doctor's name: _____	<input type="checkbox"/> Yes	Dental provider name: _____												
Provider No. _____	<input type="checkbox"/> No	Dental provider No. _____												
IPA/MG No. _____														

## Subscriber Change Request (continued)

<b>Add</b>	<b>Cancel</b>	<b>Child</b>		
<input type="checkbox"/> Dental	<input type="checkbox"/> Dental	Last name	First name	MI
<input type="checkbox"/> Medical	<input type="checkbox"/> Medical			Sex
<input type="checkbox"/> Vision	<input type="checkbox"/> Vision	Social Security number:		Date of birth (mm/dd/yyyy) _____
		<b>HMO/POS Personal Physician name</b>		<b>Dental HMO only dental provider</b>
		Doctor's name: _____		Dental provider name: _____
		Provider No. _____		Dental provider No. _____
		IPA/MG No. _____		
		Current patient?		
		<input type="checkbox"/> Yes		
		<input type="checkbox"/> No		

<b>Add</b>	<b>Cancel</b>	<b>Child</b>		
<input type="checkbox"/> Dental	<input type="checkbox"/> Dental	Last name	First name	MI
<input type="checkbox"/> Medical	<input type="checkbox"/> Medical			Sex
<input type="checkbox"/> Vision	<input type="checkbox"/> Vision	Social Security number:		Date of birth (mm/dd/yyyy) _____
		<b>HMO/POS Personal Physician name</b>		<b>Dental HMO only dental provider</b>
		Doctor's name: _____		Dental provider name: _____
		Provider No. _____		Dental provider No. _____
		IPA/MG No. _____		
		Current patient?		
		<input type="checkbox"/> Yes		
		<input type="checkbox"/> 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.