



Small Business Subscriber Change Request

Effective January 1, 2022

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

All change requests must be received within 31 days of the effective date of the change. This form is used to request changes in personal information, add/cancel dependent coverage, or change plans during open enrollment. For employees requesting a new primary care physician (HMO plans), visit **blueshieldca.com** or call Blue Shield at the number on the back of your Blue Shield member ID card.

WHICH CHANGES ARE YOU MAKING? (select all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Subscriber address | <input type="checkbox"/> Date of birth | <input type="checkbox"/> Dependent address change | <input type="checkbox"/> Date of hire |
| <input type="checkbox"/> Phone/Email address change | <input type="checkbox"/> Social Security Number | <input type="checkbox"/> Dependent addition coverage | <input type="checkbox"/> Waiving coverage |
| <input type="checkbox"/> Subscriber name change | <input type="checkbox"/> Dependent name change | <input type="checkbox"/> Effective date update | <input type="checkbox"/> Plan change |

SUBSCRIBER INFORMATION – All information requested in this section is required for all changes.

Enrolled employee (subscriber) name		Blue Shield subscriber ID number	
Social Security number (required per CMS) ____-____-____		Employment status <input type="checkbox"/> Full time (30 hrs) <input type="checkbox"/> Part time (20-29 hrs) <input type="checkbox"/> COBRA/Cal-COBRA beneficiary	
Group/employer name		Blue Shield Group ID (from ID card)	Requested effective date ____/____/____

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

MEMBER INFORMATION UPDATE

Address change

Please complete this section to update your address. Include both your full previous and full new address. HMO plans: If you have moved outside your primary care physician's service area, you will need to change primary care physician. Visit **blueshieldca.com**, or call Blue Shield at the number on your ID card for more information.

Old address	City	State	ZIP code	County
New address	City	State	ZIP code	County

Dependent name (if address change is applicable for dependent only):

Phone/email address change

Please complete this section to update your phone or email address information with Blue Shield.

Old phone number	<input type="checkbox"/> Cell <input type="checkbox"/> Landline	Old email address
New phone number	<input type="checkbox"/> Cell <input type="checkbox"/> Landline	New email address

Subscriber name	Subscriber ID number	Employer name	
Cancel coverage for all Blue Shield plans? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, please attach completed Refusal of Coverage form.	
Relationship to employee	Reason for cancellation	<input type="checkbox"/> Other insurance coverage	Event date
<input type="checkbox"/> Dependent child	<input type="checkbox"/> Divorce <input type="checkbox"/> Death	<input type="checkbox"/> Termination of domestic partnership	___/___/___
<input type="checkbox"/> Spouse/domestic partner	<input type="checkbox"/> Military deployment		
Social Security number	Date of birth	Gender: <input type="checkbox"/> Male	
_____ - _____ - _____	___/___/___	<input type="checkbox"/> Female	
First name	MI	Last name	Suffix
Address (if different from employee)	City	State	ZIP code
Cancel coverage for all Blue Shield plans? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, please attach completed Refusal of Coverage form.	

PLAN CHANGES

Plan change request

Please indicate the requested changes to coverage through an annual or special open enrollment period by completing all sections below for medical plan and specialty plan options.

Medical benefit plans: Please check with your employer to determine the benefit plans available to you.

No change to medical benefits.

Blue Shield of California Off-Exchange Package Plans

PPO plans – Full PPO Network

- | | |
|---|---|
| <input type="checkbox"/> Platinum Full PPO 0/0 OffEx | <input type="checkbox"/> Silver Full PPO 1800/45 OffEx |
| <input type="checkbox"/> Platinum Full PPO 0/10 OffEx | <input type="checkbox"/> Silver Full PPO 2225/50 OffEx* |
| <input type="checkbox"/> Platinum Full PPO 250/10 OffEx | <input type="checkbox"/> Silver Full PPO 2400/55 OffEx |
| <input type="checkbox"/> Platinum Full PPO 250/15 OffEx | <input type="checkbox"/> Bronze Full PPO 6250/65 OffEx |
| <input type="checkbox"/> Gold Full PPO 0/25 OffEx | <input type="checkbox"/> Bronze Full PPO 6850/55 OffEx |
| <input type="checkbox"/> Gold Full PPO 500/30 OffEx | <input type="checkbox"/> Bronze Full PPO 7500/65 OffEx |
| <input type="checkbox"/> Gold Full PPO 750/30 OffEx | <input type="checkbox"/> Bronze Full PPO 5500/65 OffEx |
| <input type="checkbox"/> Gold Full PPO 1000/35 OffEx | <input type="checkbox"/> Bronze Full PPO 6500/70 OffEx |

Access+ HMO plans – Access+ HMO Network

- Platinum Access+ HMO® 0/20 OffEx
- Platinum Access+ HMO® 0/25 OffEx
- Platinum Access+ HMO® 0/30 OffEx
- Gold Access+ HMO® 0/30 OffEx
- Gold Access+ HMO® 500/35 OffEx
- Gold Access+ HMO® 1000/35 OffEx
- Gold Access+ HMO® 1500/35 OffEx
- Silver Access+ HMO® 2000/60 OffEx
- Silver Access+ HMO 2750/65 OffEx

HSA-compatible HDHP plans – Full PPO Network

- Gold Full PPO Savings 1750/15% HDHP PrevRx OffEx
- Silver Full PPO Savings 2100/25% OffEx
- Silver Full PPO Savings 2600/35% HDHP PrevRx OffEx
- Bronze Full PPO Savings 5700/40% OffEx
- Bronze Full PPO Savings 7000 OffEx

Local Access+ HMO plans – Local Access+ HMO Network

- Platinum Local Access+ HMO® 0/20 OffEx
- Platinum Local Access+ HMO® 0/25 OffEx
- Platinum Local Access+ HMO® 0/30 OffEx
- Gold Local Access+ HMO® 0/30 OffEx
- Gold Local Access+ HMO® 500/35 OffEx
- Gold Local Access+ HMO® 1000/35 OffEx
- Gold Local Access+ HMO® 1500/35 OffEx
- Silver Local Access+ HMO® 2000/60 OffEx
- Silver Local Access+ HMO 2750/65 OffEx

HSA-compatible HDHP plans – Tandem PPO Network

- Gold Tandem PPO Savings 1750/15% HDHP PrevRx OffEx
- Silver Tandem PPO Savings 2100/25% OffEx
- Silver Tandem PPO Savings 2600/35% HDHP PrevRx OffEx
- Bronze Tandem PPO Savings 5700/40% OffEx
- Bronze Tandem PPO Savings 7000 OffEx

Trio HMO plans – Trio ACO HMO Network

- Platinum Trio HMO 0/20 OffEx
- Platinum Trio HMO 0/25 OffEx
- Platinum Trio HMO 0/30 OffEx
- Gold Trio HMO 0/30 OffEx
- Gold Trio HMO 500/35 OffEx
- Gold Trio HMO 1000/35 OffEx
- Gold Trio HMO 1500/35 OffEx
- Silver Trio HMO 2000/60 OffEx
- Silver Trio HMO 2750/65 OffEx
- Bronze Trio HMO 7000/70 OffEx

Tandem PPO plans – Tandem PPO Network

- Platinum Tandem PPO 0/0 OffEx
- Platinum Tandem PPO 0/10 OffEx
- Platinum Tandem PPO 250/10 OffEx
- Platinum Tandem PPO 250/15 OffEx
- Gold Tandem PPO 0/25 OffEx
- Gold Tandem PPO 500/30 OffEx
- Gold Tandem PPO 750/30 OffEx
- Gold Tandem PPO 1000/35 OffEx
- Silver Tandem PPO 1800/45 OffEx
- Silver Tandem PPO 2225/50 OffEx*
- Silver Tandem PPO 2400/55 OffEx
- Bronze Tandem PPO 6250/65 OffEx
- Bronze Tandem PPO 6850/55 OffEx
- Bronze Tandem PPO 7500/65 OffEx
- Bronze Tandem PPO 5500/65 OffEx
- Bronze Tandem PPO 6500/70 OffEx

Blue Shield of California Mirror Package Plans

- Blue Shield Platinum 90 PPO 0/15 + Child Dental
- Blue Shield Gold 80 PPO 350/25 + Child Dental
- Blue Shield Silver 70 PPO 2250/50 + Child Dental
- Blue Shield Bronze 60 PPO 6300/65 + Child Dental
- Blue Shield Trio Platinum 90 HMO 0/20 + Child Dental
- Blue Shield Trio Gold 80 HMO 250/35 + Child Dental
- Blue Shield Trio Silver 70 HMO 2250/55 + Child Dental

* The Silver Full PPO 2225/50 OffEx and Silver Tandem PPO 2225/50 OffEx offer enhanced coverage for members diagnosed with diabetes, asthma, COPD, and CAD.

Subscriber name

Subscriber ID number

Employer name

SPECIALTY BENEFIT PLANS – dental,* vision,* and life insurance* plan selection

* Only benefits your employer group offers are available for selection. Any benefits selected that are not offered by your employer group will be omitted from your enrollment.

Section SB1 – Dental coverage

Dental HMO plans

- DHMO Basic
- DHMO Standard
- DHMO Plus
- DHMO Deluxe
- DHMO Voluntary

NEW 2022 Dental PPO plans

- | | |
|---|---|
| <input type="checkbox"/> Bronze DPPO/\$1000/MAC | <input type="checkbox"/> Platinum DPPO/\$2500/U90 |
| <input type="checkbox"/> Bronze DPPO/\$1000/MAC/Child Only Ortho | <input type="checkbox"/> Platinum DPPO/\$2500/U90/Adult+Child Ortho |
| <input type="checkbox"/> Silver DPPO/\$1500/MAC | <input type="checkbox"/> Platinum DPPO/\$3000/U90 |
| <input type="checkbox"/> Silver DPPO/\$1500/MAC/Adult+Child Ortho | <input type="checkbox"/> Platinum DPPO/\$3000/U90/Adult+Child Ortho |
| <input type="checkbox"/> Silver DPPO/\$1500/U90 | <input type="checkbox"/> Platinum DPPO/\$5000/U90 |
| <input type="checkbox"/> Silver DPPO/\$1500/U90/Adult+Child Ortho | <input type="checkbox"/> Platinum DPPO/\$5000/U90/Adult+Child Ortho |
| <input type="checkbox"/> Gold DPPO/\$1500/U90 | <input type="checkbox"/> Diamond DPPO/\$3000/U95 |
| <input type="checkbox"/> Gold DPPO/\$1500/U90/Adult+Child Ortho | <input type="checkbox"/> Diamond DPPO/\$3000/U95/Adult+Child Ortho |
| <input type="checkbox"/> Gold DPPO/\$2000/U90 | <input type="checkbox"/> Diamond DPPO/\$5000/U95 |
| <input type="checkbox"/> Gold DPPO/\$2000/U90/Adult+Child Ortho | <input type="checkbox"/> Diamond DPPO/\$5000/U95/Adult+Child Ortho |

Dental PPO plans (only available for groups enrolled in these plans prior to 12/31/2021)

- | | |
|--|--|
| <input type="checkbox"/> Smile SM Value 50/1500/No Ortho/MAC/NR | <input type="checkbox"/> Smile SM Plus Gold 50/1500/Ortho/U80 |
| <input type="checkbox"/> Smile SM 50/1500/No Ortho/MAC/NR | <input type="checkbox"/> Smile SM Plus Gold 50/1500/No Ortho/U80 |
| <input type="checkbox"/> Smile SM Plus 50/1500/Ortho/MAC/NR | <input type="checkbox"/> Smile SM Plus Gold 50/1500/Ortho/U80/ADV |
| <input type="checkbox"/> Smile SM Basic 75/1000/No Ortho/MAC/NR | <input type="checkbox"/> Smile SM Plus Gold 50/1500/Ortho/U90/ADV |
| <input type="checkbox"/> Smile SM Basic 50/1000/No Ortho/MAC | <input type="checkbox"/> Smile SM Plus Gold 50/1500/No Ortho/U90/ADV |
| <input type="checkbox"/> Smile SM Basic 50/1000/Ortho/U85 | <input type="checkbox"/> Smile SM Plus Gold 50/2500/Ortho/U90/ADV |
| <input type="checkbox"/> Smile SM Plus 50/1500/No Ortho/MAC | <input type="checkbox"/> Smile SM Plus Gold 50/2500/No Ortho/U90/ADV |
| <input type="checkbox"/> Smile SM Plus 50/1500/No Ortho/MAC/WP | <input type="checkbox"/> Ultimate Dental Plus PPO for Small Business 50/2000/Ortho/MAC/NR |
| <input type="checkbox"/> Smile SM Deluxe 50/1500/Ortho/MAC/NR | <input type="checkbox"/> Ultimate Dental PPO for Small Business 50/2000/No Ortho/MAC/NR |
| <input type="checkbox"/> Smile SM Deluxe 2000 50/2000/No Ortho/MAC/NR | <input type="checkbox"/> Ultimate Dental PPO for Small Business 50/2000/No Ortho/U80 |
| <input type="checkbox"/> Smile SM Deluxe Plus 2000 50/2000/Ortho/MAC/NR | <input type="checkbox"/> Ultimate Dental PPO for Small Business 50/2000/Lifetime Ortho/U90 |
| <input type="checkbox"/> Smile SM Deluxe Gold 50/1500/Ortho/U85/NR | <input type="checkbox"/> Ultimate Dental PPO for Small Business 50/2000/No Ortho/U90 |
| <input type="checkbox"/> Smile SM Plus Gold 50/1500/Ortho/U85/NR | |

Voluntary Dental PPO Plans* (only available for groups enrolled in these plans prior to 12/31/2021)

- | | |
|--|--|
| <input type="checkbox"/> Smile SM Basic Voluntary 75/1000/No Ortho/MAC/NR | <input type="checkbox"/> Smile SM Basic Voluntary 50/1500/Ortho/U80 |
| <input type="checkbox"/> Smile SM Basic Voluntary 50/1000/No Ortho/MAC | <input type="checkbox"/> Smile SM Basic Voluntary 50/1000/No Ortho/U80 (No Wait) [†] |

NEW 2022 Voluntary Dental PPO plans**

- Bronze Voluntary DPPO/\$1000/MAC
- Bronze Voluntary DPPO/\$1000/MAC/Child Only Ortho

Dental In-Network Only (INO) plans (only available for groups enrolled in these plans prior to 12/31/2018)

- | | |
|---|---|
| <input type="checkbox"/> Smile SM INO Dental Plan 50/1500/Endo-Perio 80%/Ortho | <input type="checkbox"/> Smile SM INO Dental Plan 50/2500/Endo-Perio 80%/No Ortho |
| <input type="checkbox"/> Smile SM INO Dental Plan 50/1500/Endo-Perio 80%/No Ortho | <input type="checkbox"/> Smile SM INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/Ortho* |
| <input type="checkbox"/> Smile SM INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/Ortho* | |
| <input type="checkbox"/> Smile SM INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/No Ortho* | <input type="checkbox"/> Smile SM INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/No Ortho* |
| <input type="checkbox"/> Smile SM INO Dental Plan 50/2500/Endo-Perio 80%/Ortho | |

Dental PPO plans (only available for groups enrolled in these plans prior to 12/31/2018)

- | | |
|--|---|
| <input type="checkbox"/> Ultimate Dental Plus PPO for Small Business 50/2000/Ortho/MAC | <input type="checkbox"/> Smile SM 50/1500/No Ortho/MAC |
| <input type="checkbox"/> Ultimate Dental PPO for Small Business 50/2000/No Ortho/MAC | <input type="checkbox"/> Smile SM Plus 50/1500/Ortho/MAC |
| <input type="checkbox"/> Smile SM Deluxe 2000 50/2000/No Ortho/MAC | <input type="checkbox"/> Smile SM Value 50/1500/No Ortho/MAC |
| <input type="checkbox"/> Smile SM Deluxe Plus 2000 50/2000/Ortho/MAC | <input type="checkbox"/> Smile SM Plus Gold 50/1500/Ortho/U85 |
| <input type="checkbox"/> Smile SM Deluxe 50/1500/Ortho/MAC | <input type="checkbox"/> Smile SM Basic 75/1000/No Ortho/MAC |
| <input type="checkbox"/> Smile SM Deluxe Gold 50/1500/Ortho/U85 | <input type="checkbox"/> Smile SM Basic Voluntary 75/1000/No Ortho/MAC |

* Voluntary dental plans require a minimum of one (1) enrolling, eligible employee.

† This Voluntary plan does not include Waiting Periods and submission of proof of any prior coverage is not required.

** The voluntary plans include a 12-month waiting period on major services and orthodontic services (ortho plan).

ADV stands for Advantage. ADV plans incentivize members to use in-network providers. NR stands for No Rollover.

Subscriber name _____ Subscriber ID number _____ Employer name _____

Section SB2 – Vision coverage*

Ultimate Vision for Small Business (12-12-12)

- Ultimate Vision Plus 0/0/150/150
- Ultimate Vision 0/0/150
- Ultimate Vision Plus 10/25/150/150
- Ultimate Vision 10/25/150
- Ultimate Vision 0/0/120
- Ultimate Vision 10/25/120
- Ultimate Vision Voluntary 10/25/150¹

Preferred Vision for Small Business (12-12-24)

- Preferred Vision Plus 0/0/150/150
- Preferred Vision 0/0/150
- Preferred Vision Plus 10/25/150/150
- Preferred Vision 10/25/150
- Preferred Vision 0/0/120
- Preferred Vision 10/25/120
- Preferred Vision Voluntary 10/25/120¹

Basic Vision for Small Business (12-24-24)

- Basic Vision Plus 0/0/150/150
- Basic Vision 0/0/150
- Basic Vision Plus 10/25/150/150
- Basic Vision 10/25/150
- Basic Vision 0/0/120
- Basic Vision 10/25/120
- Basic Vision Voluntary 10/25/120¹

Other (please specify) _____

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

¹ Voluntary vision plans require a minimum of one (1) enrolling, eligible employee.

Section SB3 – Life/AD&D insurance

Group term life insurance*

Employee information

Full-time employment date _____ Average hours worked per week _____ Earnings \$ _____
 (excluding overtime, bonuses, etc.)

Rehire date _____ Class/occupation _____ Hour Week
 Month Year

Designation of beneficiary

Community property laws – If you are married or in a domestic partnership, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin) and name someone other than your spouse/domestic partner as beneficiary, it is possible that payment of benefits will be delayed or disputed unless your spouse/domestic partner also signs the beneficiary designation.

I agree to the stated beneficiary designation(s).

Spouse/domestic partner signature _____ Date _____

Spouse/domestic partner name (please print)

Primary beneficiary – Blue Shield Life will pay the life insurance benefits to the primary beneficiary/beneficiaries identified. An employee may designate more than one primary beneficiary. Please show percentages for each primary beneficiary in the “% of benefits” column to total 100% of benefits. If the percentage is not defined, the benefits will be distributed equally to those primary beneficiaries who survive the employee. To designate more than two primary beneficiaries, please provide on a separate sheet of paper, which is signed and dated by the employee, and attach to this form.

First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits
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Address	City	State	ZIP code
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First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits
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Address	City	State	ZIP code
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Subscriber name

Subscriber ID number

Employer name

ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge and agree: All information I have provided on this form is accurate and complete to the best of my knowledge and belief. 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.

Signature of employee _____ **Date** ____/____/____

Print employee name _____

Keep a copy of this document for your files.

Blue Shield of California protects the privacy of your personal information, including your individually identifiable health information. We will not disclose your personal information without your authorization, except as permitted or required by law. To obtain a copy of Blue Shield's Notice of Privacy Practices, call the customer service number on your Blue Shield member ID card or visit our website at blueshieldca.com/privacy.

**PLEASE BE SURE TO RETURN ALL PAGES OF THIS FORM. Missing information or pages may delay processing.
Complete your Subscriber Change Request form at blueshieldca.com.**

Notices available online

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: blueshieldca.com/notices. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en blueshieldca.com/notices. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 blueshieldca.com/notices。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。