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?	2. If yes, please select one:	3. Which race(s) do you identify with? (select one)	
☐ Yes ☐ No ☐ Unknown ☐ Declined	☐ Cuban ☐ Guatemalan ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Salvadoran ☐ 2 or more Ethnicities ☐ Other Hispanic, Latino, Spanish: ________________	☐ 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	Current patient?	**Dental HMO only dental provider**
Doctor's name: ________________ Provider #: ________________ IPA/MG #: ________________	☐ Yes ☐ No	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	Current patient?	**Dental HMO only dental provider**
Doctor's name: ________________ Provider #: ________________ IPA/MG #: ________________	☐ Yes ☐ No	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.

Blue Shield of California is an independent member of the Blue Shield Association C675-1-ML-REV1-FF (1/23)

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)**。