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 or taxpayer identification 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

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

☐ 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. ☐ This is a change made during special enrollment.

☐ Transfer/add my health coverage to:

- ☐ Access+ HMO® _____
- ☐ Trio HMO _____
- ☐ Active Choice® Plus _____
- ☐ Full PPO Savings _____
- ☐ Tandem PPO Savings _____
- ☐ Virtual Blue℠ _____
- ☐ Local Access+ HMO _____
- ☐ Full PPO _____
- ☐ Active Choice® Classic _____
- ☐ Tandem PPO _____
- ☐ Added Advantage POS℠ _____

☐ Transfer my Account-Based Health Plan (ABHP) benefits coverage to:

For Access+ HMO®: ☐ 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® 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
For Added Advantage POS℠: ☐ HRA ☐ HIA ☐ FSA
For Virtual Blue℠: ☐ HRA ☐ HIA ☐ FSA

☐ Transfer my dental benefits coverage to:

☐ DHMO _____ ☐ DPPO _____ ☐ DINO _____

☐ Transfer my vision benefits coverage from Plan Name _____ to Plan _____

☐ 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: $ _____
Any increase is subject to approval via Evidence of Insurability (EOI)

☐ 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: _____

☐ Check here if you are a 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 26 (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: $ _____ (subject to EOI)

☐ Change the Supplemental Group Term Life and AD&D insurance coverage amount of the child(ren): (provide prior coverage amount and new coverage amount) Prior amount of coverage: $ _____
New amount of coverage: $ _____ (subject to EOI)

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: The effective date of benefits for newborn or adopted children is from the moment of birth or the moment the child is placed in the physical custody of the insured person, spouse, or domestic partner. This automatic and unconditional coverage extends for 31 days after the birth, adoption, or placement. Requests to add a child to your coverage should be submitted within 31 days of the date of birth, adoption, or placement for adoption to continue coverage after 31 days.

Please be sure to return this form as the fifth 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
		Social Security number or taxpayer identification 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: $ _____ Subject to approval via Evidence of Insurability (EOI) If adding Basic 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	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
		Social Security number or taxpayer identification number:		Date of birth (mm/dd/yyyy)	
		If adding Supp. Life and/or Supp. AD&D insurance, please indicate amount requested: $ _____ Subject to approval via Evidence of Insurability (EOI)			
		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

Social Security number or taxpayer identification number:	Date of birth (mm/dd/yyyy)

If adding Supp. Life and/or Supp AD&D insurance, please indicate amount:
$ ________________ Subject to approval via Evidence of Insurability (EOI)
(Note: All children will be covered for the same amount for Supplemental Life and Supplemental AD&D coverage.)

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

Social Security number or taxpayer identification number:	Date of birth (mm/dd/yyyy)

If adding Supp. Life and/or Supp AD&D insurance, please indicate amount:
$ ________________ Subject to approval via Evidence of Insurability (EOI)
(Note: All children will be covered for the same amount for Supplemental Life and Supplemental AD&D coverage.)

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

Social Security number or taxpayer identification number:	Date of birth (mm/dd/yyyy)

If adding Supp. Life and/or Supp AD&D insurance, please indicate amount:
$ ________________ Subject to approval via Evidence of Insurability (EOI)
(Note: All children will be covered for the same amount for Supplemental Life and Supplemental AD&D coverage.)

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 #: ____________________

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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.

For your protection, California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Blue Shield of California/Blue Shield Life protects the confidentiality and privacy of your personal information. Personal and health information, which may be individually identifiable, 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 fifth 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.