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 plan directly.

Employee identification – this section must be completed.

Subscriber ID number (from ID card) | 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?

If yes, please indicate dependent name and address change: ____
____

☐ Requested effective date: ____/____/_______

☐ 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)

☐ Transfer/add my coverage to: ☐ HMO ______ ☐ PPO ______ ☐ POS ______ ☐ Active Choice SM* ______
☐ PPO Savings ______ ☐ DHMO ______ ☐ DPPO ______
From Group No. ______________ to Group No. ______________ in my employer group.
Note: If transferring coverage to HMO, POS, or DHMO, please complete Section A.

☐ Correct/change name 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 ____
☐ Is this a termination? If yes, list name(s): ____

Dependent coverage changes

☐ **Add dependent(s)**
Date of marriage/divorce if adding/canceling spouse: ____/____/_______
Domestic partner – date of domestic partnership/termination if adding/canceling: ____/____/_______

☐ **Cancel dependent(s)**
If custody, enter date of adoption or date placed for adoption, and attach copy of legal documents: ____/____/_______
Requested effective date for additions/deletions: ____/____/_______
Employer groups: If applicable, please have employee provide a copy of the HIPAA certificate if enrolling self and/or dependent(s) as a health plan participant during open enrollment (OE), or if employee is adding dependent(s) to their 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 to be added to the employee's coverage.

Please be sure to return this form as the second page contains your signature which is necessary to process these changes.

An Independent Member of the Blue Shield Association

Subscriber Change Request (continued)

Section A

Please check which benefit the change applies to:
Complete this section only if transferring to HMO, POS, and/or dental HMO plan(s). D = Dental or M = Medical

Add		Cancel		Self				
D	**M**	**D**	**M**	Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ____/____/_______
				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**				
D	**M**	**D**	**M**	Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ____/____/_______
				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**				
D	**M**	**D**	**M**	Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ____/____/_______
Is this dependent a full-time student? ☐ Yes ☐ No				**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**				
D	**M**	**D**	**M**	Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ____/____/_______
Is this dependent a full-time student? ☐ Yes ☐ No				**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**				
D	**M**	**D**	**M**	Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ____/____/_______
Is this dependent a full-time student? ☐ Yes ☐ No				**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. ________	

For group coverage employer verification:
Employer must sign for any subscriber name change, subscriber cancellation, dependent addition/deletion or transfer to a different group number or section/billing unit.

Employer signature ________________________________ Date ____/____/_______

Employee signature ________________________________ Date ____/____/_______

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.

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.

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

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