

# Small Group 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. Please refer to the phone number on the back of your ID card.

### 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			Apt #
City	State	ZIP code	
Group/employer name:		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/change email address to: \_\_\_\_\_

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<sup>SM\*</sup> \_\_\_\_\_  Shield Savings<sup>SM</sup> \_\_\_\_\_  
 DHMO \_\_\_\_\_  DPPO \_\_\_\_\_  Vision \_\_\_\_\_  Life Insurance<sup>1</sup> \_\_\_\_\_

From Group No. \_\_\_\_\_ to Group No. \_\_\_\_\_ in my employer group.

**Note: If transferring coverage to HMO, POS, or DHMO coverage, please complete Section A on page 2.**

Correct/change name to: \_\_\_\_\_

Correct/change my date of birth from: \_\_\_/\_\_\_/\_\_\_\_\_ to: \_\_\_/\_\_\_/\_\_\_\_\_

Additional changes/comments: \_\_\_\_\_

COBRA participant

Qualifying event and date \_\_\_\_\_

### Dependent coverage changes

#### Add dependent(s) – Complete section A

Requested effective date for additions: \_\_\_/\_\_\_/\_\_\_\_\_

Date of marriage if adding spouse: \_\_\_/\_\_\_/\_\_\_\_\_

Domestic partner – date of domestic partnership if adding \_\_\_/\_\_\_/\_\_\_\_\_

Newborn child – date of birth: \_\_\_/\_\_\_/\_\_\_\_\_

If court ordered custody, please give date and attach copy of legal documents: \_\_\_/\_\_\_/\_\_\_\_\_

If adoption, enter date of adoption or date placed for adoption, and attach copy of legal documents: \_\_\_/\_\_\_/\_\_\_\_\_

Enroll/reenroll dependent child – If reenrollment, date dependent was last covered on this group plan: \_\_\_/\_\_\_/\_\_\_\_\_

#### Cancel dependent(s)

Requested effective date for deletions: \_\_\_/\_\_\_/\_\_\_\_\_

Date of divorce if canceling spouse: \_\_\_/\_\_\_/\_\_\_\_\_

Domestic partner – date of domestic partnership termination: \_\_\_/\_\_\_/\_\_\_\_\_

Other \_\_\_\_\_

**PLEASE NOTE: A completed Refusal of Coverage (C19927) is required for dependent's cancelling coverage but remaining eligible.**

Please 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 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 to be added to your coverage.

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

1 Evidence of Insurability form may be required.

**Please be sure to return all pages of this form as the second page contains your signature which is necessary to process these changes. Fax requests to (209) 367-6475. Missing information may delay processing.**

# Subscriber Change Request (continued)

## Section A

Please check which benefit the change applies to: **M = Medical plan, D = Dental plan, V = Vision Plan, or L = Life insurance**

**Complete this section if adding/canceling dependents or if transferring to HMO, POS, and/or dental HMO plan(s).**

**Provide Personal Physician/Dental provider information if the change pertains to HMO/POS/DHMO coverage.**

<b>Add</b> <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	<b>Cancel</b> <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	<b>Self</b>			Social Security number			
		Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ____/____/____		
		<b>HMO/POS Personal Physician name</b>			Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Dental HMO only dental provider</b>	
		Doctor's Name: _____ Provider No. _____ IPA/MG No. _____			Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental provider name: _____ Dental provider No. _____	
<b>Add</b> <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	<b>Cancel</b> <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	<b>Spouse/domestic partner</b>			Social Security number			
		Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ____/____/____		
		<b>HMO/POS Personal Physician name</b>			Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Dental HMO only dental provider</b>	
		Doctor's Name: _____ Provider No. _____ IPA/MG No. _____			Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental provider name: _____ Dental provider No. _____	
<b>Add</b> <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	<b>Cancel</b> <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	<b>Child</b>			Social Security number			
		Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ____/____/____		
		<b>HMO/POS Personal Physician name</b>			Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Dental HMO only dental provider</b>	
		Doctor's Name: _____ Provider No. _____ IPA/MG No. _____			Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental provider name: _____ Dental provider No. _____	
<b>Add</b> <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	<b>Cancel</b> <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	<b>Child</b>			Social Security number			
		Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ____/____/____		
		<b>HMO/POS Personal Physician name</b>			Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Dental HMO only dental provider</b>	
		Doctor's Name: _____ Provider No. _____ IPA/MG No. _____			Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental provider name: _____ Dental provider No. _____	
<b>Add</b> <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	<b>Cancel</b> <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	<b>Child</b>			Social Security number			
		Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ____/____/____		
		<b>HMO/POS Personal Physician name</b>			Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Dental HMO only dental provider</b>	
		Doctor's Name: _____ Provider No. _____ IPA/MG No. _____			Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental provider name: _____ Dental provider No. _____	
<b>Add</b> <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	<b>Cancel</b> <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V <input type="checkbox"/> L	<b>Child</b>			Social Security number			
		Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ____/____/____		
		<b>HMO/POS Personal Physician name</b>			Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Dental HMO only dental provider</b>	
		Doctor's Name: _____ Provider No. _____ IPA/MG No. _____			Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dental provider name: _____ Dental provider 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.**