Small Group Subscriber Change Request

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

blue of california

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)

☐ Correct/change name to: _____

☐ Correct/change my date of birth from: ____/____/_____ to: ____/____/_____

☐ Additional changes/comments: _____

☐ COBRA participant _____

Qualifying event _____ Qualifying event date ____/____/_____

Dependent coverage changes

Add dependent(s) – Complete section A on the following page

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 yourself as a health plan participant and/or 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.

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

Section A – Enrollment changes and dependent additions

Transfer/add my coverage to: ☐ Premier PPO† __________ ☐ Enhanced PPO*,† __________ ☐ Base PPO *,† __________ ☐ Shield Spectrum PPO℠ *,† __________
☐ Simple Savings*, __________ ☐ HMO Premier __________ ☐ HMO Enhanced __________ ☐ DPPO __________
☐ DINO*,† __________ ☐ DHMO __________ ☐ Vision __________ ☐ Life Insurance[1] __________ ☐ Other ______________
From Group No. ______________ to Group No. ______________ in my employer group.

Please identify which benefit the change applies to: **Medical plan, Dental plan, Vision Plan, or Life insurance. Complete this section if adding/canceling dependents or if transferring to HMO and/or dental HMO plan(s). Provide Personal Physician/Dental provider information if the change pertains to HMO/DHMO coverage.**

Add	Cancel	**Self**		Social Security number		
☐ **M** ☐ **D** ☐ **V** ☐ **L**	☐ **M** ☐ **D** ☐ **V** ☐ **L**	Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ___/___/____
		HMO Personal Physician 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**		Social Security number		
☐ **M** ☐ **D** ☐ **V** ☐ **L**	☐ **M** ☐ **D** ☐ **V** ☐ **L**	Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ___/___/____
		HMO Personal Physician 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	**Dependent child**		Social Security number		
☐ **M** ☐ **D** ☐ **V** ☐ **L**	☐ **M** ☐ **D** ☐ **V** ☐ **L**	Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ___/___/____
		HMO Personal Physician 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	**Dependent child**		Social Security number		
☐ **M** ☐ **D** ☐ **V** ☐ **L**	☐ **M** ☐ **D** ☐ **V** ☐ **L**	Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ___/___/____
		HMO Personal Physician 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	**Dependent child**		Social Security number		
☐ **M** ☐ **D** ☐ **V** ☐ **L**	☐ **M** ☐ **D** ☐ **V** ☐ **L**	Last name	First name	MI	Sex	Date of birth (Mo./Day/Yr.) ___/___/____
		HMO Personal Physician Doctor's Name: ____________ Provider No. ____________ IPA/MG No. ____________	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: ____________ Dental provider No. ____________		

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.

Employee signature ______________________________ **Date** ___/___/____

If faxing this form, keep this document for your files.

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

† All Premier PPO plans (except Premier PPO 20) Enhanced PPO, Base PPO, Shield Spectrum PPO, and Simple Savings and Smile In-Network Only dental plans are pending regulatory approval.

1 Evidence of Insurability form may be required.

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