

Small Group Subscriber Change Request



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

Please fill in circles (selections) as opposed to inserting a check mark.
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

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:

Last name

First name

MI

Home street address

City

State

Zip code

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 health coverage to: Premier PPO† Enhanced PPO*†
- Base PPO*† Shield Spectrum PPOSM Plan*† Simple Savings*†
- HMO Premier HMO Enhanced DPPO DINO*†
- DHMO Vision Life Insurance¹ Other

From Group No. - to Group No. -

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

Correct/change name to:

Last name First name MI

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

Requested effective date for additions: / /

Date of marriage if adding spouse: / /

Domestic partner – date of domestic partnership if adding: / /

New born child - Date of birth: / /

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: / /

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

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

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

¹ Evidence of Insurability form may be required.

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

Cancel dependent(s)

Requested effective date for deletions: / /

Date of Divorce if cancelling spouse: / /

Domestic Partnership - 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: 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.

Section A

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

Self		Last name	<input type="text"/>	First name	<input type="text"/>	MI	<input type="text"/>
Add	Cancel		<input type="text"/>		<input type="text"/>		<input type="text"/>
<input type="radio"/> Medical	<input type="radio"/> Medical	Date of birth (mm/dd/yyyy)	<input type="text"/>	Sex	<input type="radio"/> Male	<input type="radio"/> Female	Social Security number
<input type="radio"/> Dental	<input type="radio"/> Dental	<input type="text"/>					<input type="text"/>
<input type="radio"/> Vision	<input type="radio"/> Vision						
<input type="radio"/> Life	<input type="radio"/> Life	Disabled?:	<input type="radio"/> Yes	<input type="radio"/> No			

HMO Personal Physician name

Doctor's last name	<input type="text"/>	Doctor's first name	<input type="text"/>
Provider number	<input type="text"/>	IPA/MG number	<input type="text"/>
		Current patient:	<input type="radio"/> Yes <input type="radio"/> No

Dental HMO only provider name

Dental provider's last name	<input type="text"/>	Dental provider's first name	<input type="text"/>
Dental provider number	<input type="text"/>		

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

Child Last name First name MI

Add Medical Dental Vision Life

Cancel Medical Dental Vision Life

Date of birth (mm/dd/yyyy) Sex Male Female Social Security number

Disabled?: Yes No

HMO Personal Physician name

Doctor's last name Doctor's first name

Provider number IPA/MG number Current patient: Yes No

Dental HMO only provider name

Dental provider's last name Dental provider's first name Dental provider No.

Child Last name First name MI

Add Medical Dental Vision Life

Cancel Medical Dental Vision Life

Date of birth (mm/dd/yyyy) Sex Male Female Social Security number

Disabled?: Yes No

HMO Personal Physician name

Doctor's last name Doctor's first name

Provider number IPA/MG number Current patient: Yes No

Dental HMO only provider name

Dental provider's last name Dental provider's first 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 (mo/day/yr)

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 ALL PAGES OF THIS FORM AS THIS PAGE CONTAINS YOUR SIGNATURE WHICH IS NECESSARY TO PROCESS THESE CHANGES.