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.

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 **CA**	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℠* _____
☐ 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.

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.

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