GROUP MEMBERSHIP CHANGE FORM

Please print clearly using a ball point pen • Complete applicable information only

Type of Change: ☐ Name ☐ Address ☐ Dependent Status ☐ Medical/Dental Office ☐ Life Insurance ☐ Declining Coverage

Name of Subscriber (Last)	(First)	Member ID No.	Group Medical No.	Group Dental No.	Life Group No.

NAME CHANGE

☐ Subscriber name only ☐ Entire family

New Name

ADDRESS CHANGE

New Address

City/State/ZIP Code

New Phone No.
( )

MEDICAL/DENTAL OFFICE CHANGE

☐ **Office Change***

* For medical office changes, please indicate below under the Blue Cross HMO℠ (CaliforniaCare) IPA Primary Care Physician Code Section.

Dental Office No:

TERMINATION

☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Life (includes AD&D and Supplemental Life)**

DEPENDENT STATUS CHANGE

☐ **Add Domestic Partner -** Date of registration: _____ / _____ / _____

☐ **Add Spouse -** Date of marriage: _____ / _____ / _____

☐ **Add Family Member -** Effective Date: _____ / _____ / _____

Reason: _____

Is family member currently being added on Medicare? ☐ Yes ☐ No

If yes: ☐ Part A ☐ Part B ☐ Both

Name of Medicare dependent: _____

☐ **Remove Family Member(s) -** Effective Date: _____ / _____ / _____

Name(s): _____ Reason: _____

DECLINATION INFORMATION

I understand that if I terminate or decline coverage at this time, if I choose to apply for enrollment at a later date, I may be excluded from coverage until the employer's next open enrollment, or 12-months from date of application, at which time I may reapply for coverage.

In addition, once reenrolled, I understand that my coverage may be subject to a six month exclusion for pre-existing conditions. This exclusion also applies to any dependents on this declination. If you are declining coverage for yourself, your spouse, domestic partner or your dependents because of other health insurance coverage, you must tell us. You may enroll yourself or your dependents in this plan provided you request enrollment within 31 days after your coverage ends. You may also enroll following marriage (with your spouse), registration (with your domestic partner), childbirth or adoption (with your spouse and that child only) provided you request enrollment within 31 days after the marriage, registration, birth or adoption.

LIFE BENEFICIARY

Primary Name (first to receive payment)	%	Relationship	Date of Birth	Social Security No.	Secondary Name (second to receive payment)	%	Relationship	Date of Birth	Social Security No.

FAMILY ADDITIONS

Complete the information below for all family and/or spouse additions or medical office selections and/or changes. Check the disabled box only if the condition prohibits the member from working or performing daily activities. Please indicate if family member is covered by another health insurance plan by checking the Other Health coverage box. Complete the Prior Coverage section below, if applicable. For Blue Cross HMO and POS plans only, each person listed must choose a Medical Group or Independent Practice Association (IPA) within their enrollment area. IF YOU SELECT AN IPA, YOU MUST INDICATE A PRIMARY CARE PHYSICIAN FROM WITHIN THAT IPA. If you need assistance, contact Blue Cross at the number listed on your Membership ID Card or your health benefit officer.

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

Relation	Sex	Last Name	First Name	M.I.	Social Security No.	Coverage	Date of Birth Mo / Day / Yr	Age	Totally Disabled	Other Health Coverage	If children are age 19 or over, you must check the appropriate boxes below		Medical Group/IPA Office No.	Blue Cross HMO℠ IPA Primary Care Physician Code	Is this your current doctor?
											Qualified as IRS dependent	Full time student			
Self	☐ M ☐ F					☐ Medical ☐ Dental ☐ Vision			☐ Y ☐ N	☐ Y ☐ N					☐ Y ☐ N
☐ Spouse ☐ Domestic Partner	☐ M ☐ F					☐ Medical ☐ Dental ☐ Vision			☐ Y ☐ N	☐ Y ☐ N					☐ Y ☐ N
Child	☐ M ☐ F					☐ Medical ☐ Dental ☐ Vision			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N			☐ Y ☐ N
Child	☐ M ☐ F					☐ Medical ☐ Dental ☐ Vision			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N			☐ Y ☐ N
Child	☐ M ☐ F					☐ Medical ☐ Dental ☐ Vision			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N			☐ Y ☐ N
Child	☐ M ☐ F					☐ Medical ☐ Dental ☐ Vision			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N			☐ Y ☐ N

PRIOR COVERAGE

If, immediately prior to becoming eligible for this plan, you or your eligible dependents were covered under any public or private health care coverage, please complete the section below to receive credit for that coverage. According to Federal Law, your employer or former carrier must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

Name	Date Began	Date Ended	Prior Carrier Name	Reason for Ending Coverage	Name	Date Began	Date Ended	Prior Carrier Name	Reason for Ending Coverage

Blue Cross of California and BC Life & Health Insurance Company are Independent Licensees of the Blue Cross Association.
Vision and Life Insurance coverage offered by BC Life & Health Insurance Company.
www.bluecrossca.com

FOR OFFICE USE ONLY

Effective Date:

Subscriber's Signature

X

Date

WHITE - Blue Cross Membership **YELLOW -** Employer **PINK -** Employee