Blue Shield of California
Life & Health Insurance Company
An Independent Licensee of the Blue Shield Association

Blue Shield of California
An Independent Member of the Blue Shield Association

SUBSCRIBER CHANGE REQUEST

mylifepath.com

(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	MIDDLE INITIAL
HOME STREET ADDRESS	CITY	ST ZIP
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 I.D., 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 # – TO GROUP # –
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 _____ / _____ / _____ 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 DEP(S) AS A HEALTH PLAN PARTICIPANT DURING OPEN ENROLLMENT (OE), OR IF EMPLOYEE IS ADDING DEP(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 BOTH PAGES OF THIS FORM AS THE SECOND PAGE CONTAINS YOUR SIGNATURE WHICH IS NECESSARY TO PROCESS THESE CHANGES.

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SECTION A

SUBSCRIBER ID NUMBER: ______________________________

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 D	ADD M	CANCEL D	CANCEL M	**SELF**			
				LAST NAME FIRST M		SEX	DATE OF BIRTH - MO. DAY YR.
				HMO/POS PERSONAL PHYSICIAN NAME DR.'S NAME: ______ PROV. # ______ IPA/MG # ______	CURRENT PATIENT ☐ YES ☐ NO	**DENTAL HMO ONLY DENTAL PROVIDER** DENTAL PROVIDER NAME: ______ DENTAL PROVIDER #: ______	
ADD D	ADD M	CANCEL D	CANCEL M	**SPOUSE/DOMESTIC PARTNER**			
				LAST NAME FIRST M		SEX	DATE OF BIRTH - MO. DAY YR.
				HMO/POS PERSONAL PHYSICIAN NAME DR.'S NAME: ______ PROV. # ______ IPA/MG # ______	CURRENT PATIENT ☐ YES ☐ NO	**DENTAL HMO ONLY DENTAL PROVIDER** DENTAL PROVIDER NAME: ______ DENTAL PROVIDER #: ______	
ADD D	ADD M	CANCEL D	CANCEL M	**CHILD**			
				LAST NAME FIRST M	SEX	DATE OF BIRTH - MO. DAY YR.	IS THIS DEPENDENT A FULL TIME STUDENT?
				HMO/POS PERSONAL PHYSICIAN NAME DR.'S NAME: ______ PROV. # ______ IPA/MG # ______	CURRENT PATIENT ☐ YES ☐ NO	**DENTAL HMO ONLY DENTAL PROVIDER** DENTAL PROVIDER NAME: ______ DENTAL PROVIDER #: ______	
ADD D	ADD M	CANCEL D	CANCEL M	**CHILD**			
				LAST NAME FIRST M	SEX	DATE OF BIRTH - MO. DAY YR.	IS THIS DEPENDENT A FULL TIME STUDENT?
				HMO/POS PERSONAL PHYSICIAN NAME DR.'S NAME: ______ PROV. # ______ IPA/MG # ______	CURRENT PATIENT ☐ YES ☐ NO	**DENTAL HMO ONLY DENTAL PROVIDER** DENTAL PROVIDER NAME: ______ DENTAL PROVIDER #: ______	
ADD D	ADD M	CANCEL D	CANCEL M	**CHILD**			
				LAST NAME FIRST M	SEX	DATE OF BIRTH - MO. DAY YR.	IS THIS DEPENDENT A FULL TIME STUDENT?
				HMO/POS PERSONAL PHYSICIAN NAME DR.'S NAME: ______ PROV. # ______ IPA/MG # ______	CURRENT PATIENT ☐ YES ☐ NO	**DENTAL HMO ONLY DENTAL PROVIDER** DENTAL PROVIDER NAME: ______ DENTAL PROVIDER #: ______	

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 constitute the entire agreement for coverage.

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.

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

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