Small Business Subscriber Change Request

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

blue of california

All change requests must be received within 31 days of the effective date of the change. This form is used to request changes in personal information, add/cancel dependent coverage, or change plans during open enrollment. For employees requesting a new Personal Physician (HMO plans), visit **blueshieldca.com** or call Blue Shield at the number on the back of your Blue Shield member ID card.

Subscriber information – All information requested in this section is required for all changes.

Enrolled employee (subscriber) name	Blue Shield subscriber ID number	
Social Security number (required per CMS) ___ ___ ___-___ ___-___ ___ ___ ___	Employment status ☐ Full time (30 hrs) ☐ Part time (20-29 hrs) ☐ COBRA/Cal-COBRA beneficiary	
Group/employer name	Blue Shield Group ID (from ID card)	Requested effective date ___/___/_____

Member information update

Address change

Please complete this section to update your address. Include both your full previous and full new address. HMO plans: If you have moved outside your Personal Physician's service area, you will need to change Personal Physicians. Visit **blueshieldca.com**, or call Blue Shield at the number on your ID card for more information.

Old address	City	State	ZIP code	County
New address	City	State	ZIP code	County

Dependent name (if address change is applicable for dependent only):

Phone/email address change

Please complete this section to update your phone or email address information with Blue Shield.

Old phone number	☐ Work ☐ Home	Old email address
New phone number	☐ Work ☐ Home	New email address

Employee name change – documentation may be required

Note: Documentation is required, such as copy of court order, marriage license, driver's license, or ID card.

Old name	New name
Reason for change: ☐ Marriage ☐ Divorce ☐ Other (please specify):	Documentation attached? ☐ Yes ☐ No

Date of birth correction – documentation required

Note: Documentation may be required such as a copy of the driver's license, ID card, or birth certificate.

Member's name	Date of birth ___/___/_____	Documentation attached? ☐ Yes ☐ No

Social Security number correction/change – documentation required

A copy of the Social Security card, letter of verification from the Social Security Office, and a written statement explaining the reason for the change are required.

Old Social Security number ___ ___ ___-___ ___-___ ___ ___ ___	New Social Security number ___ ___ ___-___ ___-___ ___ ___ ___	Documentation attached? ☐ Yes ☐ No

Subscriber name	Subscriber ID number	Employer name

Member eligibility changes

Dependent addition of coverage
Please complete this section to add a spouse, domestic partner, or dependent child to the employee's coverage. Please copy and attach additional pages as needed if adding multiple dependents. The request must be received within the time frame allowed per the qualifying event, or during the group's open enrollment period. Documentation is required to verify the date of the qualifying event, including for loss of coverage, adoption, or court-ordered coverage. A completed **Refusal of Coverage (C19927)** is required for any dependent that is refusing coverage under the plan. **Note:** Social Security number is required per CMS.

Dependent 1

Relationship to employee	**Reason for addition**		**Event date**
☐ Dependent child ☐ Spouse/domestic partner ☐ Dependent child: legal guardianship	☐ Newborn ☐ Adoption ☐ Court order ☐ Marriage	☐ Domestic partnership ☐ Loss of coverage ☐ Open enrollment	____/____/_____

Social Security number ___ ___ ___ -___ ___ -___ ___ ___ ___	Date of birth ____/____/_____	Gender: ☐ Male ☐ Female

First name	**MI**	**Last name**	**Suffix**

Address (if different from employee)	City	State	ZIP code

Was the dependent covered under another health insurance plan within the past 12 months? ☐ Yes ☐ No If yes, please specify carrier and plan name, start and end dates of coverage: Carrier and plan name: _____ ____/____/_____ to ____/____/_____

HMO provider name	HMO provider number	IPA/MG name	Current patient? ☐ Yes ☐ No

Dental HMO provider name	Dental HMO provider number	Current patient? ☐ Yes ☐ No

Enrolling in same products selected by subscriber? ☐ Yes ☐ No	If no, is Refusal of Coverage form for those plans being declined attached? ☐ Yes ☐ No

Dependent 2

Relationship to employee	**Reason for addition**		**Event date**
☐ Dependent child ☐ Spouse/domestic partner ☐ Dependent child: legal guardianship	☐ Newborn ☐ Adoption ☐ Court order ☐ Marriage	☐ Domestic partnership ☐ Loss of coverage ☐ Open enrollment	____/____/_____

Social Security number ___ ___ ___ -___ ___ -___ ___ ___ ___	Date of birth ____/____/_____	Gender: ☐ Male ☐ Female

First name	**MI**	**Last name**	**Suffix**

Address (if different from employee)	City	State	ZIP code

Was the dependent covered under another health insurance plan within the past 12 months? ☐ Yes ☐ No If yes, please specify carrier and plan name, start and end dates of coverage: Carrier and plan name: _____ ____/____/_____ to ____/____/_____

HMO provider name	HMO provider number	IPA/MG name	Current patient? ☐ Yes ☐ No

Dental HMO provider name	Dental HMO provider number	Current patient? ☐ Yes ☐ No

Enrolling in same products selected by subscriber? ☐ Yes ☐ No	If no, is Refusal of Coverage form for those plans being declined attached? ☐ Yes ☐ No

Dependent cancellation of coverage
Please complete this section to cancel all Blue Shield coverage for a dependent spouse, domestic partner, or child due to loss of eligibility. If any dependents being cancelled remain eligible for coverage, or if coverage is being partially cancelled (not all plans), a completed Refusal of Coverage form is required for those plans being declined/cancelled.

Relationship to employee	**Reason for cancellation**		**Event date**
☐ Dependent child ☐ Spouse/domestic partner	☐ Divorce ☐ Death ☐ Military deployment	☐ Other insurance coverage ☐ Termination of domestic partnership	____/____/_____

Social Security number ___ ___ ___ -___ ___ -___ ___ ___ ___	Date of birth ____/____/_____	Gender: ☐ Male ☐ Female

First name	MI	Last name	Suffix

Address (if different from employee)	City	State	ZIP code

Cancel coverage for all Blue Shield plans? ☐ Yes ☐ No	If no, please attach completed Refusal of Coverage form.

Subscriber name	Subscriber ID number	Employer name

Plan changes

Plan change request

Please indicate the requested changes to coverage through an annual or special open enrollment period by completing all sections below for medical plan and specialty plan options.

Medical benefit plans: Please check with your employer to determine the benefit plans available to you.

☐ **No change to medical benefits.**

Blue Shield of California Off Exchange Package Plans	Current	New
Platinum Full PPO 0 OffEx	☐	☐
Platinum Full PPO 150 OffEx	☐	☐
Gold Full PPO 0 OffEx	☐	☐
Gold Full PPO 750 OffEx	☐	☐
Silver Full PPO 1250 OffEx	☐	☐
Silver Full PPO 1700 OffEx	☐	☐
Bronze Full PPO 4500 OffEx	☐	☐
Silver Full PPO HSA 2000 OffEx	☐	☐
Bronze Full PPO HSA 3500 OffEx	☐	☐
Bronze Full PPO HSA 5500 OffEx	☐	☐
Platinum Access+ HMO® $25 OffEx	☐	☐
Gold Access+ HMO® $30 OffEX	☐	☐
Silver Access+ HMO® $55 OffEx	☐	☐
Platinum Local Access+ HMO® $25 OffEx	☐	☐
Gold Local Access+ HMO® $30 OffEx	☐	☐
Silver Local Access+ HMO® $55 OffEx	☐	☐
Trio ACO HMO Plans		
Platinum Trio ACO HMO $25 OffEx	☐	☐
Gold Trio ACO HMO $30 OffEx	☐	☐
Silver Trio ACO HMO $55 OffEx	☐	☐

Blue Shield of California Mirror Package Plans	Current	New
Platinum 90 HMO Network 1 Mirror	☐	☐
Platinum 90 HMO Network 2 Mirror	☐	☐
Gold 80 HMO Network 1 Mirror	☐	☐
Gold 80 HMO Network 2 Mirror	☐	☐
Silver 70 HMO Network 1 Mirror	☐	☐
Silver 70 HMO Network 2 Mirror	☐	☐
Bronze 60 PPO Mirror	☐	☐

Pediatric dental benefit plans (required if selecting Medical)*	Current	New
Children's Dental PPO	☐	☐
Children's Dental HMO	☐	☐
Family Dental PPO	☐	☐
Family Dental HMO	☐	☐

* Pursuant to state and federal law, the group must have pediatric dental coverage. Therefore, employees enrolling in a Blue Shield medical plan must be enrolled in pediatric dental coverage

Specialty Benefit Plans – Dental, Vision, and Life Insurance plan selection

Please complete the attached Specialty Benefits Employee Benefit Selection form to indicate changes to specialty benefit coverage.

Section SB1 – Dental benefits

Dental HMO Plans

☐ DHMO Basic	☐ DHMO Plus	☐ DHMO Deluxe	☐ DHMO Voluntary

Dental PPO Plans

☐ Ultimate Dental PPO for Small Business 50/2000	☐ Smile℠ 50/1500/No Ortho/MAC
☐ Ultimate Dental Plus PPO for Small Business 50/2000	☐ Smile℠ Plus 50/1500/Ortho/MAC
☐ Smile℠ Deluxe 2000 50/2000/No Ortho/MAC	☐ Smile℠ Value 50/1500/No Ortho/MAC
☐ Smile℠ Deluxe Plus 2000 50/2000/Ortho/MAC	☐ Smile℠ Plus Gold 50/1500/Ortho/U85
☐ Smile℠ Deluxe 50/1500/Ortho/MAC	☐ Smile℠ Basic 75/1000/No Ortho/MAC
☐ Smile℠ Deluxe Gold 50/1500/Ortho/U85	☐ Smile℠ Basic Voluntary 75/1000/No Ortho/MAC

Dental In-Network Only (INO) Plans*

☐ Smile℠ INO Dental Plan 50/1500/Endo-Perio 80%/Ortho	☐ Smile℠ INO Dental Plan 50/2500/Endo-Perio 80%/Ortho
☐ Smile℠ INO Dental Plan 50/1500/Endo-Perio 80%/No Ortho	☐ Smile℠ INO Dental Plan 50/2500/Endo-Perio 80%/No Ortho
☐ Smile℠ INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/Ortho	☐ Smile℠ INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/Ortho
☐ Smile℠ INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/No Ortho	☐ Smile℠ INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/No Ortho

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

Section SB2 – Vision Coverage

Vision Coverage*

Ultimate Vision for Small Business (12-12-12)	Preferred Vision for Small Business (12-12-24)	Enhanced Vision for Small Business (12-24-24)
☐ Ultimate Vision Plus 0/0/150/120	☐ Preferred Vision Plus 0/0/150/120	☐ Enhanced Vision Plus 0/0/150/120
☐ Ultimate Vision 0/0/150	☐ Preferred Vision 0/0/150	☐ Enhanced Vision 0/0/150
☐ Ultimate Vision Plus 15/25/150/120	☐ Preferred Vision Plus 15/25/150/120	☐ Enhanced Vision Plus 15/25/150/120
☐ Ultimate Vision 15/25/150	☐ Preferred Vision 15/25/150	☐ Enhanced Vision 15/25/150
☐ Ultimate Vision Voluntary 15/25/150[1]	☐ Preferred Vision 0/0/120	☐ Enhanced Vision 0/0/120
☐ Ultimate Vision 0/0/120	☐ Preferred Vision 15/25/120	☐ Enhanced Vision 15/25/120
☐ Ultimate Vision 15/25/120	☐ Preferred Vision Voluntary 15/25/120[1]	☐ Enhanced Vision Voluntary 15/25/120[1]

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

1 Voluntary vision plans require a minimum of three enrolling, eligible employees.

Subscriber name	Subscriber ID number	Employer name

Section SB3 – Life/AD&D insurance

Group Term Life Insurance†

Employee information

Full-time employment date	Average hours worked per week	Rehire date	Class/occupation	Earnings $ ________________ (excluding overtime, bonuses, etc.) ☐ Hour ☐ Week ☐ Month ☐ Year

Designation of beneficiary

Primary beneficiary – Blue Shield Life will pay the life insurance benefits to the primary beneficiary/beneficiaries identified. An employee may designate more than one primary beneficiary. Please show percentages for each primary beneficiary in the "% of benefits" column to total 100% of benefits. If the percentage is not defined, the benefits will be distributed equally to those primary beneficiaries who survive the employee. To designate more than two primary beneficiaries, please provide on a separate sheet of paper, which is signed and dated by the employee, and attach to this form.

First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits
Address		City		State	ZIP code	
First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits
Address		City		State	ZIP code	

Contingent beneficiary – Proceeds will be paid to a contingent beneficiary only if no designated primary beneficiary survives the insured.

First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits
Address		City		State	ZIP code	

Information on benefit amounts

Please contact your benefits administrator for more information regarding your group life insurance coverage. Evidence of Insurability must be submitted for approval before an employee is eligible for coverage over a certain guaranteed amount or when enrolling outside of the initial eligibility period. Coverage granted to individuals listed in this enrollment form shall be subject to all provisions and limitations stated in the Blue Shield of California Life & Health Insurance Company group life insurance policy.

Employee Basic Life and AD&D Insurance amount: $ ______________	Basic Dependent Life Insurance: ☐ Yes ☐ No
Number of eligible dependents: _____________	Amount of coverage requested for dependent(s): $ ______________ (Minimum amount of coverage is $1,000; maximum is $5,000)

* Pursuant to state and federal law, the group must have pediatric dental coverage. Therefore, employees enrolling in a Blue Shield medical plan must be enrolled in Pediatric Dental Coverage.

† Underwritten by Blue Shield of California Life & Health Insurance Company.

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If transferring to HMO and/or Dental HMO plan(s), provide Personal Physician/Dental Provider information below.‡

Last name	MI	First name		Sex ☐ Male ☐ Female	Date of birth ____/____/_______
HMO provider name/number	Current patient? ☐ Yes ☐ No	Dental HMO provider name/number			Current patient? ☐ Yes ☐ No
Last name	MI	First name		Sex ☐ Male ☐ Female	Date of birth ____/____/_______
HMO provider name/number	Current patient? ☐ Yes ☐ No	Dental HMO provider name/number			Current patient? ☐ Yes ☐ No
Last name	MI	First name		Sex ☐ Male ☐ Female	Date of birth ____/____/_______
HMO provider name/number	Current patient? ☐ Yes ☐ No	Dental HMO provider name/number			Current patient? ☐ Yes ☐ No
Last name	MI	First name		Sex ☐ Male ☐ Female	Date of birth ____/____/_______
HMO provider name/number	Current patient? ☐ Yes ☐ No	Dental HMO provider name/number			Current patient? ☐ Yes ☐ No

Subscriber name	Subscriber ID number	Employer name

‡ Please note: If Blue Shield is unable to assign the Personal Physician and/or Dental HMO provider you requested, Blue Shield will designate a provider at random. HMO Personal Physicians can be changed by visiting **blueshieldca.com** after enrollment.

Acknowledgement and signature

I acknowledge and agree: 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.

Signature of employee _____ **Date** ____/____/_____

Print employee name _____

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

Blue Shield of California protects the privacy of your personal information, including your individually identifiable health information. We will not disclose your personal information without your authorization, except as permitted or required by law. To obtain a copy of Blue Shield's Notice of Privacy Practices, call the customer service number on your Blue Shield member ID card or visit our website at **blueshieldca.com/bsca/documents/about-blue-shield/privacy**.

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