10455 Mill Run Circle
Owings Mills, MD 21117

CareFirst BlueCross BlueShield

CareFirst of Maryland, Inc.

MEMBERSHIP CHANGE FORM

This is not an application for insurance

Subscriber's Name:	Birth Date:
Address:	
SSN/Subscriber Identification Number:	Phone Number:
Requested Effective Date of Change:	

CHANGES REQUESTED

☐ **Add a Dependent:**

Add a:

☐ New Born of Subscriber/Domestic Partner

☐ Child being adopted   Date received for adoption: ___/___/___   Month/Year in which final adoption papers are granted: ___/___

☐ Child for whom subscriber has been appointed legal guardian   Date appointed legal guardian: ___/___/___

Documentation required if adoption proceedings are underway or if you are a court-appointed legal guardian.

COMBINING SAME PRODUCT POLICIES (benefits must be the same or greater, if not a Minor, signature required.)

☐ Subscriber:	Subscriber ID#:	Relationship:

DEPENDENT INFORMATION (Please list all persons to be added)

Last	First	MI	Relationship	Sex	Date of Birth	Social Security Number
			Dependent		/ /	
			Dependent		/ /	
			Dependent		/ /	

☐ **Remove a Dependent:**

Due to:

☐ Divorce* Date of Divorce: ___/___/___   ☐ Extended Military   Effective Date of Termination: ___/___/___

☐ Death* Date of Death: ___/___/___   ☐ Other: ______________________

*Documentation required.

DEPENDENT INFORMATION (Please list all persons to be removed)

Last	First	MI	Relationship	Sex	Date of Birth	Social Security Number
			Dependent		/ /	
			Dependent		/ /	
			Dependent		/ /	

☐ Change of Coverage Level

Change from:	Change to:
☐ Individual	☐ Individual
☐ Individual and Child	☐ Individual and Child
☐ Individual and Adult	☐ Individual and Adult
☐ Family	☐ Family

Also fill out the dependent add/drop section when applicable.

Subscriber's Name: ______________________ Identification Number: ______________________

CHANGES REQUESTED (Continued)

Add:
☐ Vision ☐ Dental

Remove:
☐ Vision ☐ Dental

SPLIT MEMBERSHIP/CONVERT DEPENDENT TO HIS/HER OWN POLICY (If not a Minor, signature required.)

Set up for continuous coverage

Dependent's Name	Type of Current Coverage	Social Security Number	Effective Date
			/ /
			/ /

Reason

☐ Death ☐ Divorce ☐ Separation ☐ Current spouse terminating ☐ Other: ______________________

Change from:
- ☐ Individual
- ☐ Individual and Child
- ☐ Individual and Adult
- ☐ Family

Change to:
- ☐ Individual
- ☐ Individual and Child
- ☐ Individual and Adult
- ☐ Family

☐ **Increase Deductible Level**

Change from: ______________________ Change to: ______________________

☐ **Name change (documentation required)**

Change from: ______________________ Change to: ______________________

Reason for name change: ☐ Marriage ☐ Divorce ☐ Other: ______________________

☐ **Address Change**

Change from: ______________________ Change to: ______________________

☐ **Telephone number change**

Home Change from: ______________________ Change to: ______________________

Work Change from: ______________________ Change to: ______________________

HSA ONLY

By signing this Change Form, I hereby authorize CareFirst BlueCross BlueShield to disseminate and share information contained on this Form with Health Savings Account (HSA) custodian(s) affiliated with CareFirst BlueCross BlueShield. I understand that dissemination of information to any such custodian is at my direction and with my full understanding. Further that dissemination of information on this Form is necessary in order to effectuate the establishment of Health Savings Account in my name with the HSA custodian. This authorization shall continue until my enrollment with CareFirst BlueCross BlueShield terminates or at any time that I provide a written instruction to CareFirst BlueCross BlueShield revoking his authorization or if this terminates by operation of law.

If you do not want information on this form shared with the HSA custodian(s) please check here: ☐

OTHER HEALTH INSURANCE INFORMATION

Is any person listed on the change form covered by another health care plan or HMO? ☐ Yes ☐ No

If yes, will this coverage be continued? ☐ Yes ☐ No If no, please provide the cancellation date: ___/___/___

Policy Holder's Name: ______________________ Phone Number of Other Insurer: ______________________

Name and Address of Insurance Company: ______________________

Policy Number: ______________________ Group Number: ______________ Effective Date of Policy: ___/___/___

Name of Employer providing coverage (if applicable): ______________________

Does this policy cover you? ☐ Yes ☐ No Your Spouse/Partner? ☐ Yes ☐ No Your children? ☐ Yes ☐ No

Please list the name(s) of child(ren) covered: ______________________

Policyholder's working status: ☐ Active ☐ Retired Retirement date: ___/___/___

Subscriber's Name: ______________________ Identification Number: ______________________

MEDICARE INFORMATION (To be completed if applicable.)			
Are you eligible for Medicare? ☐ Yes ☐ No			
	Medicare Number:	**Hosp. Eff. Date (Part A):**	**Med. Eff. Date (Part B)**
If yes:			
Reason for entitlement: ☐ Age 65 and older ☐ End Stage Renal Disease ☐ Disabled			
Is your Spouse/Partner eligible for Medicare? ☐ Yes ☐ No			
	Medicare Number:	**Hosp. Eff. Date (Part A):**	**Med. Eff. Date (Part B)**
If yes:			
Reason for entitlement: ☐ Age 65 and older ☐ End Stage Renal Disease ☐ Disabled			
Is your Child/Dependent eligible for Medicare? ☐ Yes ☐ No			
	Medicare Number:	**Hosp. Eff. Date (Part A):**	**Med. Eff. Date (Part B)**
If yes:			
Reason for entitlement: ☐ Age 65 and older ☐ End Stage Renal Disease ☐ Disabled			
Employee Status (check only one box): ☐ Active ☐ Retired			

IF YOU HAVE OTHER HEALTH INSURANCE COVERAGE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED.

To be completed by the natural parents that live apart and provide medical coverage for their child(ren). Please indicate relationship to child(ren) (natural mother, natural father, step-parent). Parent with Court Assigned Responsibility for Child(ren)'s Medical Expenses.

Parent's Name: ______________ Date of Birth: __/__/__ Relationship to Child: ______________

Child's Name: ______________ Child's Date of Birth: __/__/__

Parent with Custody of Child(ren)

Parent's Name: ______________ Date of Birth: __/__/__ Relationship to Child: ______________

Child's Name: ______________ Child's Date of Birth: __/__/__

Required Signature(s) and Date

Subscriber's Name: ______________________ Date: ______________

Member's Name: ______________________ Date: ______________

INTERNAL USE ONLY			
Apply the changes noted in this document to program:	**CIA/IACS#:**	**EE#:**	**Effective Date of Changes:**

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www.carefirst.com

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