



Subscriber's Name: \_\_\_\_\_ Identification Number: \_\_\_\_\_

**CHANGES REQUESTED (Continued)**

Add:  Vision  Dental Remove:  Vision  Dental  Maternity (DC only)

**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(ren)  Individual and Adult  Family  
 Change to:  Individual  Individual and Child(ren)  Individual and Adult  Family

**COPAY LEVEL CHANGES (Deductible, Coinsurance, Out-of-Pocket, Prescription Drug Plan - Higher copay changes only)**

**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: \_\_\_\_\_

**ADD/CHANGE PRIMARY CARE PHYSICIAN INFORMATION**

Primary Care Physician for: \_\_\_\_\_  Medical  
 Change/Add to: Physician name: \_\_\_\_\_ PCP ID#: \_\_\_\_\_ Existing Patient?  Yes  No

Primary Care Physician for: \_\_\_\_\_  Medical  
 Change/Add to: Physician name: \_\_\_\_\_ PCP ID#: \_\_\_\_\_ Existing Patient?  Yes  No

**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:

Subscriber's Name: \_\_\_\_\_ Identification Number: \_\_\_\_\_

**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: \_\_\_ / \_\_\_ / \_\_\_

**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: \_\_\_ / \_\_\_ / \_\_\_

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the subscriber.

**Required Signature(s) and Date**

Subscriber's Name: _____	Date: _____
Member's Name: _____	Date: _____

Subscriber's Name: \_\_\_\_\_ Identification Number: \_\_\_\_\_

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

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