

GROUP HOSPITALIZATION AND MEDICAL SERVICES, 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.)

<input type="checkbox"/> Subscriber:	Subscriber ID#:	Relationship:
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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
- Death* Date of Death: ___ / ___ / ___ Other: _____ Termination: ___ / ___ / ___

***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:

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Individual <input type="checkbox"/> Individual and Child(ren) <input type="checkbox"/> Individual and Adult <input type="checkbox"/> Family | <ul style="list-style-type: none"> <input type="checkbox"/> Individual <input type="checkbox"/> Individual and Child(ren) <input type="checkbox"/> Individual and Adult <input type="checkbox"/> Family |
|---|---|

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

Subscriber's Name: _____ Identification Number: _____

CHANGES REQUESTED (Continued)

Add: Vision (Supplement 65/HSA only) Remove: Vision (Supplement 65/HSA only) Maternity
 Extended Maternity (MD 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: _____

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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