Mail To:
P.O. Box 14651
Lexington, KY 40512
Fax: **800-305-1351**
410-505-2981

CareFirst BlueCross BlueShield

MediGap-65/Supplement-65
Maryland and District of Columbia*

Membership Change Form

This is not an application for insurance.
*DC Residents must complete an application for an upgrade in coverage.

Subscriber Identification Number:	Phone Number:
Subscriber's Name:	Birth Date:

Email:

Address: Is this a new address? ☐ Yes ☐ No

Street City State Zip

Mailing Address (only if different from your Permanent Address):

Street City State Zip

CHANGES REQUESTED:

A. PLEASE SELECT A PLAN (Check One):

I want to change to:

☐ Plan A** ☐ Plan B ☐ Plan C** ☐ Plan F ☐ High Deductible Plan F ☐ Plan N

****If you are under 65 and have Medicare, you may apply for Plan A or Plan C only.**

Effective Date:
Requested Date of Coverage _____/_____/_____
MONTH DATE YEAR

Requested effective date must be a future date.

MEDICARE COVERAGE INFORMATION

Please provide the following Medicare information as printed on your red, white, and blue Medicare identification card. You must have both Medicare Part A (hospital) and Medicare Part B (medical/surgical) coverage or will obtain Medicare coverage before the effective date of this MediGap-65 or Supplement-65 policy.

Are you under the age of 65 and eligible for Medicare by reason of disability? ☐ Yes ☐ No

HEALTH INSURANCE CLAIM NUMBER:	MEDICARE HOSPITAL (PART A) EFFECTIVE DATE:	MEDICARE MEDICAL/SURGICAL (PART B) EFFECTIVE DATE:
	_____/_____/_____ MONTH DATE YEAR	_____/_____/_____ MONTH DATE YEAR

B. CHANGE REQUEST CONTINUED

Required Signature(s) and Date

Subscriber's Signature Date

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