



MEMBERSHIP CHANGE

Please indicate type of change:

- Change existing membership Reinstate Change existing COBRA

Instructions: Please complete entire form. Please print using black ink. If you have questions concerning this form, please contact your Employer. **Important:** Incomplete or omitted information may affect your effective date and payment of claims. Please read all sections carefully. Keep a copy of this form as Proof of Request for Change until you receive confirmation.

Employer Information:	Employer Name	Group No.	Effective Date of Change
Employee Information:	Social Security Number	Occupation / Title	Employee Type <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried
	Work Telephone ()	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Do you have dependents other than a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many? _____
			Home Telephone ()

Indicate the specific change(s) that you are requesting:

Name Address Dependents Medical Group/Physician Other Change _____

List member changes and/or eligible members to be enrolled below. All must live or work in the Blue Shield service area. If changes indicated for yourself apply to other members of your family as well, write "same" in the appropriate box(es).

Important: Adding dependents that are Late Enrollees as defined on the back of this form may require full medical underwriting and/or their addition delayed up to 12 months.

For HMO, SELECT & ELECT Enrollees only.
Medical Group / Physician selection*

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete	SELF	Last Name First Name MI	Birth Date / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	PMG/IPA#	Medical Group Name
		Home Address City State	ZIP		PCP#	Physician Name (Last, First)
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete	SPOUSE	Last Name First Name MI	Birth Date / /	<input type="checkbox"/> M <input type="checkbox"/> F	PMG/IPA#	Medical Group Name
		Social Security Number	Address / Telephone (if different)	Date of marriage / /	PCP#	Physician Name (Last, First)
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete	CHILD	Last Name First Name MI	Birth Date / /	<input type="checkbox"/> M <input type="checkbox"/> F	PMG/IPA#	Medical Group Name
		Social Security Number	Address / Telephone (if different)	Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP#	Physician Name (Last, First)
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete	CHILD	Last Name First Name MI	Birth Date / /	<input type="checkbox"/> M <input type="checkbox"/> F	PMG/IPA#	Medical Group Name
		Social Security Number	Address / Telephone (if different)	Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP#	Physician Name (Last, First)
<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Delete	CHILD	Last Name First Name MI	Birth Date / /	<input type="checkbox"/> M <input type="checkbox"/> F	PMG/IPA#	Medical Group Name
		Social Security Number	Address / Telephone (if different)	Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP#	Physician Name (Last, First)

* Review the Blue Shield Provider Directory and choose a medical group for yourself and each family member. Indicate number (PMG/IPA#) and name of the medical group. If the medical group you've selected has an "X" after the number (e.g., IPA 135X), be sure to indicate a Primary Care Physician (PCP) number and name for each person enrolling in that group.

REASON FOR CHANGE **MUST** be completed if adding or deleting dependents. Please attach supporting documents.

<p>Reason for ADDING dependent(s):</p> <p><input type="checkbox"/> New (Birth, adoption or marriage) Date of Event: _____</p> <p><input type="checkbox"/> Loss of prior coverage (Complete "Other Health Insurance" section)</p> <p><input type="checkbox"/> Other _____</p>	<p>Reason for DELETING dependent(s):</p> <p><input type="checkbox"/> Overage <input type="checkbox"/> Marriage</p> <p><input type="checkbox"/> Death <input type="checkbox"/> Divorce Date of Event: _____</p> <p><input type="checkbox"/> Other _____</p>
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Eligibility of dependents added for a reason other than **recent** marriage, birth or loss of prior coverage will be subject to the terms of your policy. See definition of Late Enrollees on the back of this form.

OTHER HEALTH INSURANCE

Have you and/or any eligible family members been covered by other medical insurance within the last six (6) months? Yes No
 If yes, complete this section. Attach additional sheets if needed. This information is needed for coordination of benefits and to credit enrollees who are subject to pre-existing conditions limitations for qualifying prior coverage. Blue Shield Life Insurance Company reserves the right to require proof of prior coverage and will assist you in obtaining this proof if needed.

Covered Person(s)	Coverage Through	Policy #	Carrier Name	Plan Type	Began	Ended
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Current Employer <input type="checkbox"/> Previous Employer <input type="checkbox"/> Spouse's Employer <input type="checkbox"/> Other_____	Employer's Name		<input type="checkbox"/> Health <input type="checkbox"/> Other_____		If Applicable
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Current Employer <input type="checkbox"/> Previous Employer <input type="checkbox"/> Spouse's Employer <input type="checkbox"/> Other_____	Employer's Name		<input type="checkbox"/> Health <input type="checkbox"/> Other_____		

LIFE INSURANCE BENEFICIARY If Applicable (Attach separate sheet for additional or contingent beneficiaries)

Life Beneficiary (Full Name)	Relationship	%
Life Beneficiary (Full Name)	Relationship	%

DISABILITY INFORMATION

Do you believe that you or any family member for whom you are applying for coverage under Blue Shield and Blue Shield Life Insurance Co. would be considered disabled according to the definitions of disability given below?
 Yes No If yes, complete this section.

Name of Disabled Individual	Disabling Condition	Date Disability Began

Explanation of medical release authorization: The authorization below to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et seq. of the California Civil Code. Your cooperation is requested.

Authorization to obtain or release medical information: I hereby authorize my physician, health care practitioner, hospital, clinic or other medically related facility to furnish an agent, designee or representative of Blue Shield, any and all records pertaining to medical history, services rendered or treatment given to anyone enrolled hereunder, or added hereunder for purpose of review, investigation or evaluation of an application or a claim. I authorize Blue Shield, or its agents, designees or representatives to disclose to a hospital, health care service plan, or self-insurer, any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable Blue Shield to process claims.

Arbitration Agreement: I understand that any dispute or controversy, except medical malpractice, that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled family member) and Blue Shield, Blue Shield Life Insurance Company or any Participating Medical Group/Independent Physicians Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial.

Sign and date this application below. Your signature indicates that you have completed all requested information as accurately as possible and understand all agreements implied, including your agreement to submit disputes to binding arbitration.

Employee Signature X	Date
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Late Enrollees

A dependent will be considered a Late Enrollee **unless** enrolled:

- Within 30 days of Employee's initial eligibility.
- Within 30 days of new dependent acquisition through birth, marriage or adoption.
- Within 30 days of a court order to add the dependent.
- Within 30 days of the dependent involuntarily losing prior insurance coverage.

Please attach supporting documents. A Late Enrollee will be subject to full medical underwriting and may, at the discretion of the Blue Shield, be deferred until the next Open Enrollment period. **Submission of this form is not a guarantee of acceptance by Blue Shield.**

Disabling Conditions

If you or a family member were disabled as of the date of termination of coverage with a prior health insurer, and the loss of coverage was due to the termination of the employer's insurance policy, you may be entitled to an extension of health insurance benefits according to California Insurance Code § 10128. Under this law, the prior insurer retains responsibility until whichever of the following occurs first: (a) the member is no longer totally disabled; (b) the Maximum benefits of the prior insurer's coverage are paid; or (c) a period of 12 consecutive months has passed since the date coverage ended with the prior insurer.

Total disability, as it relates to law described above, means: Employee: when, as a result of bodily injury or disease, the employee is unable to engage in any employment or occupation for which he or she is or becomes qualified for by reason of education, training or experience and is not, in fact, engaged in any employment or occupation for wage or profit. Family member: when the family member is prevented from performing all regular and customary activities usual for a person of that age and family status.