GROUP MEMBERSHIP CHANGE FORM -- CLASSIFIED

Please print clearly using a ball point pen • Complete applicable information only

Type of Change: ☐ Name ☐ Address ☐ Dependent Status ☐ Declining Coverage

Name of Subscriber (Last) (First)	Member ID No.	Group Medical No.	Social Security No.

NAME CHANGE

☐ Subscriber name only ☐ Entire family

New Name

ADDRESS CHANGE

New Address

City/State/ZIP Code

New Phone No.
( )

TERMINATION

☐ **Medical**

DEPENDENT STATUS CHANGE

☐ **Add Spouse** - Date of marriage: ___/___/___

☐ **Add Family Member** - Effective Date: ___/___/___

Reason: ___

Is family member on Medicare? ☐ Yes ☐ No

If yes: ☐ Part A ☐ Part B ☐ Both

Name of Medicare dependent: ___

☐ **Remove Family Member(s)** - Effective Date: ___/___/___

Reason: ___

DECLINATION INFORMATION

I understand that if I terminate or decline coverage at this time, if I choose to apply for enrollment at a later date, I may be excluded from coverage until the employer's next open enrollment, or 12-months from date of application, at which time I may reapply for coverage.

If you are declining coverage for yourself, your spouse, or your dependents because of other health insurance coverage, you must tell us. You may enroll yourself or your dependents in this plan provided you request enrollment within 31 days after your coverage ends. You may also enroll following marriage (with your spouse), childbirth or adoption (with your spouse and that child only) provided you request enrollment within 31 days after the marriage, birth or adoption.

List names below of dependents to be added or dropped from your medical coverage.

Complete the information below for all family and/or spouse additions or medical office selections and/or changes. Check the disabled box only if the condition prohibits the member from working or performing daily activities. Please indicate if family member is covered by another health insurance plan by checking the Other Health coverage box. Complete the Prior Coverage section below, if applicable.

If adding dependents you must provide: Marriage Certificate, Birth Certificate(s) or proof of legal adoption to validate each dependent you are applying to add to your medical coverage.

Relation	Sex	Last Name	First Name	M.I.	Social Security No.	Coverage	Date of Birth Mo / Day / Yr	Age	Totally Disabled	Other Health Coverage	If children are age 19 or over, you must check the appropriate boxes below	
											Qualified as IRS dependent	Full time student
Self	☐ M ☐ F					☐ Medical			☐ Y ☐ N	☐ Y ☐ N		
☐ Spouse	☐ M ☐ F					☐ Medical			☐ Y ☐ N	☐ Y ☐ N		
Child	☐ M ☐ F					☐ Medical			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Child	☐ M ☐ F					☐ Medical			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Child	☐ M ☐ F					☐ Medical			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Child	☐ M ☐ F					☐ Medical			☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

PRIOR COVERAGE

If, immediately prior to becoming eligible for this plan, you or your eligible dependents were covered under any public or private health care coverage, please complete the section below to receive credit for that coverage. According to Federal Law, your employer or former carrier must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

Name	Date Began	Date Ended	Prior Carrier Name	Reason for Ending Coverage	Name	Date Began	Date Ended	Prior Carrier Name	Reason for Ending Coverage

Blue Cross of California and BC Life & Health Insurance Company are Independent Licensees of the Blue Cross Association.
Vision and Life Insurance coverage offered by BC Life & Health Insurance Company.
www.bluecrossca.com

FOR OFFICE USE ONLY

Effective Date:

Subscriber's Signature

X

Date