

Change Form

For group coverage



PremierBlue

www.bcbsks.com

Section 1

Always complete this section:

Name Last (Sr., Jr., etc.) First MI

Address Street

City State ZIP Code County

Gender Male Female Date of Birth MM DD YYYY

Social Security No. - - Home Phone No. - - Area Code

Employed by Work Phone No. - - Area Code

Member ID No. Group No.

To add family members, complete this section:

Change to family due to: Birth/Adoption Marriage
 Divorce Involuntary Loss of Coverage

Date of this occurrence MM DD YYYY

I want to enroll in:

	Health	Dental
Myself only	<input type="checkbox"/>	<input type="checkbox"/>
Myself and my spouse	<input type="checkbox"/>	<input type="checkbox"/>
Myself and my child(ren)	<input type="checkbox"/>	<input type="checkbox"/>
Myself and my family	<input type="checkbox"/>	<input type="checkbox"/>

Spouse (complete this section if spouse is included in plan)

Name Last (Sr., Jr., etc.) First MI

Gender Male Female Date of Birth MM DD YYYY

Social Security No. - - Date of Marriage MM DD YYYY

Primary Care Physician Name City

Dependent

Name Last (Sr., Jr., etc.) First MI

Gender Male Female Date of Birth MM DD YYYY Full Time Student? Yes No

Social Security No. - - Relationship to employee: Child Stepchild Other

Primary Care Physician Name City

Dependent

Name Last (Sr., Jr., etc.) First MI

Gender Male Female Date of Birth MM DD YYYY Full Time Student? Yes No

Social Security No. - - Relationship to employee: Child Stepchild Other

Primary Care Physician Name City

Do you or any of your listed dependents have Medicare Parts A and/or B? Yes No

Name of family member with coverage:

Last (Sr., Jr., etc.) First MI

Medicare No. Part A effective date MM DD YYYY

Part B effective date MM DD YYYY

Sec. 2 Are you entitled to Medicare due to ESRD (permanent kidney failure)? Yes No

Is anyone enrolling in this coverage entitled to benefits for surgical, medical or dental expenses from any other group insurance (excluding Medicare, SRS, Medicaid)? Yes No

To drop family members, complete this section:

Check one: Change to myself only Change to myself and my spouse Change to myself and my child(ren)
 Retain family and terminate coverage for: _____

Give reason: Divorce Death Child married Other (give reason): _____

Date of occurrence MM - DD - YYYY

Section 3

Last	Name First	M.I.	Date of Birth		
			Month	Day	Year

To change the Primary Care Physician, complete this section: (Blue Select or Premier Blue only)**

Change will be effective the first of the month following receipt of request.

Reason for change: _____

Section 4

Name Last First MI

New Primary Care Physician Name City

Name Last First MI

New Primary Care Physician Name City

To change name, address and phone number, complete this section:

**If Blue Select or Premier Blue, address change may require PCP change.

Change name to:

Section 5

Name Last First MI

Change address to:

Address Street

City State ZIP Code County

Change telephone number to: Area Code

Other changes and comments:

Section 6

To receive credit for any waiting periods for pre-existing conditions under your previous coverage, you must submit a Certificate of Creditable Coverage. Contact your previous employer and/or insurer.

To process the above changes, please sign and date:

Signature **X** _____ Date _____

Signature of group administrator _____ Date _____