

**Blue Shield of California and
Blue Shield of California Life & Health Insurance Company
Subscriber IFP Plan Change Request Form**



Use this form to request a change to a new health plan for subscribers and/or other enrolled family members, or to request a rating tier reconsideration. If you would like to add a family member or domestic partner to your plan, or if you are currently a member of a Blue Shield group health plan, guaranteed issue plan, individual conversion plan, or Post-MRMIP graduate plan, please use the Application for Blue Shield Individual and Family Health Plans (Form C12900-RD-PR). If you have been enrolled for 12 months and are requesting a transfer without underwriting, complete this form, with the exception of part 5.

Instructions: Form must be typed or completed in blue or black ink. For help filling out this form, contact your broker or call Blue Shield at (800) 431-2809. Send your completed form to: Blue Shield, P.O. Box 3008, Lodi, CA 95241-1912. Or fax it to (209) 367-2420. Please do not include dues/premiums.

Part 1 A – Choose health plan (check one box only)

Active StartSM plans* <input type="checkbox"/> 25 <input type="checkbox"/> 25 Generic Rx ¹ <input type="checkbox"/> 35 <input type="checkbox"/> 35 Generic Rx ¹	Shield Spectrum PPOSM plans <input type="checkbox"/> PPO 5000* <input type="checkbox"/> PPO 5500 ¹	Shield SavingsSM plans* <input type="checkbox"/> 1800/3600 ¹ <input type="checkbox"/> 3500 ¹ <input type="checkbox"/> 4000/8000 <input type="checkbox"/> 5200 ¹	Vital ShieldSM plans*¹ <input type="checkbox"/> 900 <input type="checkbox"/> 2900 Vital ShieldSM Plus plans*¹ <input type="checkbox"/> 400 <input type="checkbox"/> 400 Generic Rx <input type="checkbox"/> 900 <input type="checkbox"/> 900 Generic Rx <input type="checkbox"/> 2900 <input type="checkbox"/> 2900 Generic Rx
Access+ plans <input type="checkbox"/> HMO <input type="checkbox"/> Value HMO			
BalanceSM plans*¹ <input type="checkbox"/> 1000 <input type="checkbox"/> 1700 <input type="checkbox"/> 2500			
EssentialSM packages* <input type="checkbox"/> 1750 ¹ <input type="checkbox"/> 3000 <input type="checkbox"/> 4500			
<input type="checkbox"/> Bridge Plan*¹ (hospital insurance indemnity rider – available for Shield Savings 3500, 4000/8000, and 5200)			
<input type="checkbox"/> Other: _____			

* Underwritten by Blue Shield of California Life & Health Insurance Company.
¹ Pending regulatory approval.

Part 1 B – Choose an option below if you would like to add dental coverage to your health plan

Dental plan options (check one): Dental HMO Dental PPO Value SmileSM PPO Specialty Duo (dental + vision package)*

Dental HMO only: You must choose a dental provider from the *Blue Shield Dental HMO Dental Provider Directory*, available at blueshieldca.com, or call (800) 431-2809.

The dental provider you choose will provide or arrange dental care for you and all covered dependents.

If Dental HMO: Dental provider No.: _____

If Dental HMO: Dental provider name: _____

Part 1 C – Move individuals to separate plans

Check here if you would like to move family members to separate health plans.

List family members to move to separate plan:

Family member name: _____ Plan: _____

Family member name: _____ Plan: _____

Do the remaining family members wish to stay on their current plan? Yes No

Part 2 – Rating tier reconsideration

Check here if you are requesting a reconsideration of your rating tier.

Part 3 – Subscriber information

Blue Shield subscriber No.	First name	MI	Last name	
Married: <input type="checkbox"/> Yes <input type="checkbox"/> No	Work phone No.	Home phone No.		Social Security No.
Domestic partner: <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Check here if this is a new address				
Home address (no P.O. Box)	City	State	ZIP code	County of residence
Billing address (if different from home address)	City	State	ZIP code	
Mailing address: <input type="checkbox"/> Same as home <input type="checkbox"/> Same as billing (if different from home or billing address, provide below)	City	State	ZIP code	

Please check your preferred method of contact: Home telephone Work telephone E-mail Standard mail E-mail address: _____

Please indicate language preference: English Spanish Chinese Vietnamese Other: _____

If you need additional space, attach a supplemental page providing all information requested below. Please provide information identified by family member, and sign and date every attachment. Check here if a supplemental page is attached.

Part 4 – List all currently enrolled members requesting a plan change

Relationship	Combine into one family plan	First name	Middle initial	Last name (if different than provided in Part 3)	Social Security No.	Date of birth Mo./Day/Yr.
Subscriber: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No				____ - ____ - ____	__ / __ / ____
<input type="checkbox"/> Husband <input type="checkbox"/> Wife	<input type="checkbox"/> Yes <input type="checkbox"/> No				____ - ____ - ____	__ / __ / ____
Domestic partner: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No				____ - ____ - ____	__ / __ / ____
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Yes <input type="checkbox"/> No				____ - ____ - ____	__ / __ / ____
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Yes <input type="checkbox"/> No				____ - ____ - ____	__ / __ / ____
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Yes <input type="checkbox"/> No				____ - ____ - ____	__ / __ / ____

Part 5 – Please answer the following questions for yourself and each family member listed in Part 4

Note: if you are requesting a transfer without underwriting, you may skip Part 5 and proceed to Part 6.

1. Have you or any covered family member had any condition that resulted in a surgery, hospitalization, or visit to an emergency room, within the past two years? Yes No

Name(s) of family member(s)	Reason for visit/diagnosis	Treatment(s) received	Date treatment(s) began	Date treatment(s) ended	Full name and address of facility and physician providing treatment
			__ / __ / ____	__ / __ / ____	

2. Other than routine physical exams with normal findings, have you or any covered family member had any medical consultation, treatment, or testing during the past six months? Yes No

Name(s) of family member(s)	Reason for visit/diagnosis	Was follow-up required? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list details.	Full name and address of health provider consulted

3. Are you or any covered family member currently taking prescription drugs? Yes No

Name(s) of family member(s)	Name(s) of medication(s)	Reason(s) for prescription(s)

4. Are you, or your spouse, domestic partner or any dependent (whether covered or not covered under your plan) currently pregnant or in the process of adoption or surrogate pregnancy? Yes No

Name(s) of family member(s)	Relationship to subscriber

5. Are you, or your spouse, domestic partner or any dependent expecting a child with anyone, even if the expecting mother is not covered under your plan or listed on this form? Yes No

Name(s) of family member(s)	Relationship to subscriber

6. In the past 12 months have you or any covered family member had, or currently have:

a) Any illness or infection lasting more than a week, not mentioned elsewhere on this form?					Yes <input type="checkbox"/> No <input type="checkbox"/>
b) A physical injury requiring medical attention?					Yes <input type="checkbox"/> No <input type="checkbox"/>
c) Any medical diagnosis by a licensed health practitioner, not mentioned elsewhere on this form?					Yes <input type="checkbox"/> No <input type="checkbox"/>
Name(s) of family member(s)	Type(s) of condition(s)	Type(s) of future treatment(s)	Estimated date of treatment(s)	Please provide complete details	
			__ / __ / ____		

Please read and include this page when submitting this form, even if no information is provided.

Part 6 – HMO plans only: complete this section if you are requesting to enroll in an HMO plan

The Blue Shield HMO plans are available only in those Plan Service Areas specified in the *Blue Shield HMO Physician and Hospital Directory*, available at blueshieldca.com. A subscriber must live or work in an HMO plan service area. Select a Personal Physician for yourself and each of your eligible family members from the list of Personal Physicians in the *Blue Shield HMO Physician and Hospital Directory* for your service area. You may choose the same or a different Blue Shield HMO Personal Physician for each family member. Be sure to include each Personal Physician's provider number as listed in the directory. If you have questions about completing this section, contact your broker or call Blue Shield at (800) 431-2809.

Relationship	Name	Personal Physician name			Provider No.	Current patient
		First name	Middle initial	Last name		
Subscriber: <input type="checkbox"/> Male <input type="checkbox"/> Female						<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Domestic partner						<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No

Do all listed family members reside with subscriber? Yes No If no, identify the individual and give address:

Name	Address
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Subscriber's occupation	Subscriber's employer		
Employer address	City	State	ZIP code
Spouse's/domestic partner's occupation	Spouse's/domestic partner's employer		
Employer address	City	State	ZIP code

Part 7 – Authorizations, terms, and conditions

In addition to the terms and conditions for IFP plan coverage previously agreed upon, the following apply. Please read this Part 7 carefully. Each member age 18 and older is required to review the completed form and provide their own authorization and signature. Keep a copy of this form for your records.

1. If your request to change plans is approved, the Underwriting Department will assign an effective date of the transfer. Until your request is approved, you should maintain your current coverage. Continue making payments on your current plan until you receive notification that your change request has been approved.
2. The rate and plan option approved may vary depending on underwriting determination. If you do not qualify for the plan option you selected, you may be enrolled in a higher deductible plan or a higher rate may apply. You will be notified of your plan and rate by the Underwriting Department. You have the option to transfer back to your previous plan and rate at that time.
3. The rate for your family plan is based on the cumulative health risk of each member. If you are considering requesting that your family contract be split into separate contracts and grouping the healthiest family members together, please be aware that separate contracts and rates could result in an even higher total rate than the original contract.
4. If approved, this Subscriber IFP Plan Change Request Form, together with the original Application for Blue Shield Individual and Family Health Plans, *Evidence of Coverage and Health Service Agreement/Policy*, any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage. Your broker cannot approve this plan change request form or change any terms or conditions of coverage.
5. Authorization for spouse/domestic partner to make changes: If your spouse/domestic partner is also requesting coverage, please specify if you authorize your spouse/domestic partner to make additions or changes to the request form/contract/policy on your behalf. Yes No
Note: You may discontinue this authorization at any time by sending a written request to Blue Shield.

6. HIV OR GENETIC TESTING PROHIBITED: No genetic information, including family medical history, and no information related to HIV testing should be provided. California law prohibits an HIV test from being required or used by a health insurance company or healthcare service plan as a condition of obtaining health coverage.

Part 7 – Authorizations, terms, and conditions (continued)

I alone am responsible for the accuracy and completeness of the information provided on this plan change request form. I have personally reviewed all information provided on this form, even if I did not fill out the form myself. To the best of my knowledge and belief, all information on this form, including all information provided in the medical history section of this form, is accurate, true and complete. If Blue Shield determines that information on this form is materially inaccurate, not true or incomplete, I understand that coverage may be cancelled or, if the inaccuracy, untruthfulness, or incompleteness was intentional, coverage may be rescinded. I further understand that I must provide Blue Shield with any new information that arises after submission of this form but before the effective date of any change begins.

All members 18 and older must sign and date this form. Keep a copy of this form for your records.

X _____ / / _____
 Signature of subscriber/parent (or legal guardian) Today's date (required) Print name (and relationship if subscriber is a minor)

X _____ / / _____
 Signature of subscriber's spouse/domestic partner Today's date (required) Print name
 (if applicable)

X _____ / / _____
 Signature of family member age 18 and over Today's date (required) Print name
 (if applicable)

X _____ / / _____
 Signature of family member age 18 and over Today's date (required) Print name
 (if applicable)

Process to authorize Blue Shield to release personal information to others: If you would like to authorize your spouse, domestic partner, or a third party to access your personal health information, please complete the form titled *Authorization for Blue Shield to Disclose Personal & Health Information to a Third Party*. To obtain this form, go to blueshieldca.com or call (800) 431-2809.

Part 8 – If this plan change request form is submitted through a broker, the broker must complete the section below.

Do you want the service agreement/policy sent directly to the subscriber? Yes No

I did not assist the subscriber in any way in completing or submitting this form. All information was completed by the subscriber with no assistance or advice of any kind from me.

I assisted the subscriber in submitting this form. All information in the health questionnaire was provided by them. I advised the subscriber that they should answer all questions completely and truthfully and that no information requested on the form should be withheld. I explained that, if information is withheld, that could result in their coverage being cancelled later. The subscriber indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the form is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to \$10,000.

Broker No.	Telephone No.	Fax No.
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Broker name

Broker address

City	State	ZIP code
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E-mail address

X _____ / / _____
 Broker signature (required) Today's date (required)