

## SUBSCRIBER CHANGE REQUEST

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(All changes must be received within 31 days of the effective date of change)  
This form cannot be used for Primary Care Physician (PCP) changes – subscriber must call plan directly.

### EMPLOYEE IDENTIFICATION — This section must be completed.

SUBSCRIBER ID NUMBER (FROM ID CARD)		GROUP NUMBER (FROM ID CARD)	
WORK TELEPHONE (      )		HOME TELEPHONE (      )	
LAST NAME	FIRST NAME	MIDDLE INITIAL	
HOME STREET ADDRESS	CITY	ST	ZIP
GROUP/EMPLOYER NAME (IF APPLICABLE):		E-MAIL ADDRESS	

### CHANGES

YES  NO IS THIS A CHANGE/CORRECTION OF ADDRESS?  
 YES  NO IS THE CHANGE/CORRECTION OF ADDRESS FOR A DEPENDENT?  
 IF YES, PLEASE INDICATE DEPENDENT NAME AND ADDRESS CHANGE \_\_\_\_\_

REQUESTED EFFECTIVE DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

CORRECT MY SOCIAL SECURITY NUMBER TO: \_\_\_\_\_  
 (COPY of Social Security card, A Photo I.D., a letter of verification from the social security office and a written statement of why the employee is requesting the change, must be attached)

TRANSFER/ADD MY COVERAGE TO:  HMO \_\_\_\_\_  PPO \_\_\_\_\_  POS \_\_\_\_\_  ACTIVE CHOICE\* \_\_\_\_\_  
 PPO Savings \_\_\_\_\_  DHMO \_\_\_\_\_  DPPO \_\_\_\_\_

FROM GROUP # \_\_\_\_\_ TO GROUP # \_\_\_\_\_  
 IN MY EMPLOYER GROUP. NOTE: IF TRANSFERRING COVERAGE TO HMO, POS OR DHMO, PLEASE COMPLETE SECTION A.

CORRECT/CHANGE NAME TO:  
 CORRECT/CHANGE MY DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ TO: \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDITIONAL CHANGES/COMMENTS:  
 SUBSCRIBER CANCELLATION: I DECLINE HEALTH PLAN COVERAGE FOR MYSELF (AND DEPENDENTS IF ANY)  
 EFFECTIVE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 COBRA PARTICIPANT  
 QUALIFYING EVENT \_\_\_\_\_

IS THIS A TERMINATION? IF YES, LIST NAME/S:

### DEPENDENT COVERAGE CHANGES

ADD DEPENDENT(S) DATE OF MARRIAGE/DIVORCE IF ADDING/CANCELING SPOUSE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 DOMESTIC PARTNER – DATE OF DOMESTIC PARTNERSHIP/TERMINATION IF ADDING/CANCELING: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 CANCEL DEPENDENT(S) IF CUSTODY, ENTER DATE OF ADOPTION OR DATE PLACED FOR ADOPTION AND ATTACH COPY OF  
 LEGAL DOCUMENTS: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 REQUESTED EFFECTIVE DATE FOR ADDITIONS/DELETIONS: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 EMPLOYER GROUPS: IF APPLICABLE, PLEASE HAVE EMPLOYEE PROVIDE A COPY OF THE HIPAA CERTIFICATE IF  
 ENROLLING SELF AND/OR DEP(S) AS A HEALTH PLAN PARTICIPANT DURING OPEN ENROLLMENT (OE), OR IF  
 EMPLOYEE IS ADDING DEP(S) TO THEIR COVERAGE OUTSIDE OE WITH A QUALIFYING EVENT.  
 QUALIFYING EVENT: \_\_\_\_\_ QUALIFYING EVENT DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

NOTE: NEWBORN/ADOPTED CHILDREN OR CHILDREN PLACED FOR ADOPTION REQUIRE A COMPLETED SUBSCRIBER CHANGE REQUEST TO BE SUBMITTED WITHIN 31 DAYS FROM THE DATE OF BIRTH/ADOPTION TO BE ADDED TO THE EMPLOYEE'S COVERAGE.

**SECTION A**

SUBSCRIBER ID NUMBER: \_\_\_\_\_

PLEASE CHECK WHICH BENEFIT THE CHANGE APPLIES TO: COMPLETE THIS SECTION ONLY IF TRANSFERRING TO HMO, POS AND/OR DENTAL HMO PLAN(S)  
D = DENTAL OR M = MEDICAL

<b>ADD</b> D M	<b>CANCEL</b> D M	<b>SELF</b>
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LAST NAME	FIRST	M	SEX	DATE OF BIRTH - MO. DAY YR.
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<b>HMO/POS PERSONAL PHYSICIAN NAME</b> DR.'S NAME: _____ PROV. # _____ IPA/MG # _____	<b>CURRENT PATIENT</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>DENTAL HMO ONLY DENTAL PROVIDER</b> DENTAL PROVIDER NAME: _____ DENTAL PROVIDER #: _____
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<b>ADD</b> D M	<b>CANCEL</b> D M	<b>SPOUSE/DOMESTIC PARTNER</b>
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LAST NAME	FIRST	M	SEX	DATE OF BIRTH - MO. DAY YR.
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<b>HMO/POS PERSONAL PHYSICIAN NAME</b> DR.'S NAME: _____ PROV. # _____ IPA/MG # _____	<b>CURRENT PATIENT</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>DENTAL HMO ONLY DENTAL PROVIDER</b> DENTAL PROVIDER NAME: _____ DENTAL PROVIDER #: _____
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<b>ADD</b> D M	<b>CANCEL</b> D M	<b>CHILD</b>
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LAST NAME	FIRST	M	SEX	DATE OF BIRTH - MO. DAY YR.	IS THIS DEPENDENT A FULL TIME STUDENT?
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<b>HMO/POS PERSONAL PHYSICIAN NAME</b> DR.'S NAME: _____ PROV. # _____ IPA/MG # _____	<b>CURRENT PATIENT</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>DENTAL HMO ONLY DENTAL PROVIDER</b> DENTAL PROVIDER NAME: _____ DENTAL PROVIDER #: _____
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<b>ADD</b> D M	<b>CANCEL</b> D M	<b>CHILD</b>
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LAST NAME	FIRST	M	SEX	DATE OF BIRTH - MO. DAY YR.	IS THIS DEPENDENT A FULL TIME STUDENT?
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<b>HMO/POS PERSONAL PHYSICIAN NAME</b> DR.'S NAME: _____ PROV. # _____ IPA/MG # _____	<b>CURRENT PATIENT</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>DENTAL HMO ONLY DENTAL PROVIDER</b> DENTAL PROVIDER NAME: _____ DENTAL PROVIDER #: _____
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<b>ADD</b> D M	<b>CANCEL</b> D M	<b>CHILD</b>
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LAST NAME	FIRST	M	SEX	DATE OF BIRTH - MO. DAY YR.	IS THIS DEPENDENT A FULL TIME STUDENT?
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<b>HMO/POS PERSONAL PHYSICIAN NAME</b> DR.'S NAME: _____ PROV. # _____ IPA/MG # _____	<b>CURRENT PATIENT</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>DENTAL HMO ONLY DENTAL PROVIDER</b> DENTAL PROVIDER NAME: _____ DENTAL PROVIDER #: _____
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**FOR GROUP COVERAGE EMPLOYER VERIFICATION:**  
EMPLOYER MUST SIGN FOR ANY SUBSCRIBER NAME CHANGE, SUBSCRIBER CANCELLATION, DEPENDENT ADDITION/DELETION OR TRANSFER TO A DIFFERENT GROUP NUMBER OR SECTION/BILLING UNIT.

**EMPLOYER SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_

**EMPLOYEE SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_

All information I have provided on this form is accurate and complete. I understand that this form, along with any prior enrollment form, the evidence of coverage/certificate of insurance and health service agreement/policy, and any endorsements and attachments thereto, collectively constitute the entire agreement for coverage.

**IF FAXING THIS FORM, KEEP THIS DOCUMENT FOR YOUR FILES.**

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