

**SUBSCRIBER IFP PLAN CHANGE REQUEST FORM**

Use this form to request a change to a new health plan for adult or YouthCare<sup>SM</sup> 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-DS). This can be found at [blueshieldca.com](http://blueshieldca.com) or by calling (800) 431-2809.

**Instructions:** Form must be typed or completed in blue or black ink. For help filling out this form, call Blue Shield at (800) 431-2809 or contact your agent or broker. Send your completed form to: Blue Shield, P.O. Box 629013, El Dorado Hills, CA 95762-9013. Or fax it to (916) 350-7500. Do not include dues/premiums.

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

<input type="checkbox"/> Active Start <sup>SM</sup> Plan 35* <input type="checkbox"/> Active Start Plan 25* <input type="checkbox"/> Essential Plan <sup>SM</sup> 1750* <sup>1</sup> <input type="checkbox"/> Essential Plan 3000* <input type="checkbox"/> Essential Plan 4500* <input type="checkbox"/> Balance Plan <sup>SM</sup> 1000* <sup>1</sup> <input type="checkbox"/> Balance Plan 1700* <sup>1</sup> <input type="checkbox"/> Balance Plan 2500* <sup>1</sup>	<b>Shield Spectrum PPO<sup>SM</sup> Plans</b> <input type="checkbox"/> PPO Plan 500 <input type="checkbox"/> PPO Plan 750 <input type="checkbox"/> PPO Plan 1500 <input type="checkbox"/> PPO Plan 2000 <input type="checkbox"/> PPO Plan 5000* <input type="checkbox"/> Blue Shield Life PPO Plan 1500* <input type="checkbox"/> Blue Shield Life PPO Plan 2000*	<b>Shield Spectrum PPO<sup>SM</sup> Savings Plans</b> <input type="checkbox"/> PPO Savings Plan 2400 (individual) <input type="checkbox"/> PPO Savings Plan 4800 (family) <input type="checkbox"/> PPO Savings Plan 4000* (individual) <input type="checkbox"/> PPO Savings Plan 8000* (family)	<b>Blue Shield HMO Plans</b> <input type="checkbox"/> Access+ HMO <sup>®</sup> Plan <input type="checkbox"/> Access+ Value HMO <sup>SM</sup> Plan
		<input type="checkbox"/> Other: _____	

\*Underwritten by Blue Shield of California Life & Health Insurance Company.

<sup>1</sup> 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

**Dental HMO only:** You must choose a dental provider from the *Blue Shield Dental HMO Dental Provider Directory*, available at [blueshieldca.com](http://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	Domestic Partner <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone No.	Home Phone No.		Social Security Number
<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 above)		City	State	ZIP Code	
Mailing Address (if different from home address)		City	State	ZIP Code	

If you need additional space, please attach an additional sheet of paper listing the required information. Identify the family member and sign and date every attachment. Check here for attachment.

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

Relationship	Consider for separate YouthCare plan	First Name	MI	Last Name (if different from above)	Social Security No.	Date Of Birth Mo./Day/Yr.
Self: <input type="checkbox"/> Male <input type="checkbox"/> Female	Not applicable				____ - ____ - ____	___ / ___ / ____
<input type="checkbox"/> Husband <input type="checkbox"/> Wife	Not applicable				____ - ____ - ____	___ / ___ / ____
Domestic Partner: <input type="checkbox"/> Male <input type="checkbox"/> Female	Not applicable				____ - ____ - ____	___ / ___ / ____
<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.**

**1. Have you or any covered family member had any condition that resulted in a surgery or hospitalization within the past two years? Yes  No**

Name of Family Member(s)	Condition(s) Diagnosed	Type(s) of Treatment(s) Received	Date Treatment Began	Date Treatment Ended	Full Name and Address of Physician Providing Treatment
			___ / ___ / ___	___ / ___ / ___	

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

Name of Family Member(s)	Condition(s) Diagnosed	Was follow-up required? If yes, please list details.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Full Name And Address of Physician Providing Treatment

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

Name of Family Member(s)	Name of Medication(s)	Reason(s) for Prescription

**4. Are you or any family member, covered or not covered under your plan, currently pregnant or in the process of adoption or of surrogate pregnancy? Yes  No**

Name of Family Member(s)	Relationship to Subscriber

**5. Do you or any covered family member have any other symptom, condition, or health problem that you are aware of, that has not yet been evaluated by a licensed health professional? Yes  No**

Name of Family Member(s)	Type 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 – HMOs only: complete this section if you are requesting to enroll in one of our HMO plans**

The Blue Shield HMOs are available only in those Plan Service Areas specified in the Blue Shield HMO Physician and Hospital Directory, available at [blueshieldca.com](http://blueshieldca.com). 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, call Blue Shield at (800) 431-2809 or contact your agent or broker.

Relationship	First Name	Personal Physician Name			Provider No.	Current Patient
		First Name	MI	Last Name		
Self: <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: \_\_\_\_\_

Subscriber’s Occupation and Employer	Employer Address	City	State	ZIP Code
Spouse’s/Domestic Partner’s Occupation and 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 carefully. Your authorization and signature are required below:

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 agent or broker cannot approve this Plan Change Request Form or change any terms or conditions of coverage.
5. **HIV TESTING PROHIBITED:** California law prohibits an HIV test from being required or used by a health insurance company or health care service plan as a condition of obtaining health coverage.
6. 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.

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

I have read the summary of benefits and understand the terms and conditions of coverage for the health plan I am requesting. I understand and agree to each of them. I alone am responsible for the accuracy and completeness of the information provided on this plan change request form. I understand that neither I, nor any family members, will be eligible for coverage if any information is false or incomplete. I also understand that if coverage is issued, it may be revoked upon such a finding.

**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 Today's Date (required) Print Name (and relationship if subscriber is a minor)  
 (or legal guardian)

X \_\_\_\_\_ / / \_\_\_\_\_  
 Signature of Subscriber's Spouse/ Today's Date (required) Print Name  
 Domestic Partner (if applicable)

X \_\_\_\_\_ / / \_\_\_\_\_  
 Signature of Family Member Age 18 and Today's Date (required) Print Name  
 Over (if applicable)

X \_\_\_\_\_ / / \_\_\_\_\_  
 Signature of Family Member Age 18 and Today's Date (required) Print Name  
 Over (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](http://blueshieldca.com) or call (800) 431-2809.

**Part 8 – If this plan change request form is submitted through a producer (agent), the producer must complete the section below.**

Producer No. Telephone No. Fax No.

Producer Name

Producer Address

City State ZIP Code

Email Address

X \_\_\_\_\_ / / \_\_\_\_\_  
 Producer Signature (required) Today's Date (required)

**PRODUCER CERTIFICATION**

1. Are you aware of any information not disclosed in this request form, which may have a bearing on this request?  
 Yes, explain  No

2. Did you see the subscriber, and did you ask each question in this request form exactly as set forth, and are the answers recorded exactly as given to you?  Yes  No

3. Who completed this request form?  
 Producer  Subscriber

4. Do you want the Service Agreement/Policy sent directly to the subscriber?  
 Yes  No