Blue Shield of California and
Blue Shield of California Life & Health Insurance Company

blue of california

SUBSCRIBER IFP PLAN CHANGE REQUEST FORM

Use this form to request a change to a new health plan for adult or YouthCare[SM] 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** 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)

☐ Active Start[SM] Plan 35*	**Shield Spectrum PPO[SM] Plans**	**Shield Spectrum PPO[SM] Savings Plans**	**Blue Shield HMO Plans**
☐ Active Start Plan 25*	☐ PPO Plan 500	☐ PPO Savings Plan 2400 (individual)	☐ Access+ HMO® Plan
☐ Essential Plan[SM] 1750*[1]	☐ PPO Plan 750	☐ PPO Savings Plan 4800 (family)	☐ Access+ Value HMO[SM] Plan
☐ Essential Plan 3000*	☐ PPO Plan 1500	☐ PPO Savings Plan 4000* (individual)	
☐ Essential Plan 4500*	☐ PPO Plan 2000	☐ PPO Savings Plan 8000* (family)	
☐ Balance Plan[SM] 1000*[1]	☐ PPO Plan 5000*		
☐ Balance Plan 1700*[1]	☐ Blue Shield Life PPO Plan 1500*	☐ Other: _____	
☐ Balance Plan 2500*[1]	☐ Blue Shield Life PPO Plan 2000*		

*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

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 member 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 ☐ Yes ☐ No	Domestic Partner ☐ Yes ☐ No	Work Phone No.	Home Phone No.	Social Security Number

☐ 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: ☐ Male ☐ Female	Not applicable				_____ – _____ – _____	___ / ___ / _____
☐ Husband ☐ Wife	Not applicable				_____ – _____ – _____	___ / ___ / _____
Domestic Partner: ☐ Male ☐ Female	Not applicable				_____ – _____ – _____	___ / ___ / _____
☐ Son ☐ Daughter	☐ Yes ☐ No				_____ – _____ – _____	___ / ___ / _____
☐ Son ☐ Daughter	☐ Yes ☐ No				_____ – _____ – _____	___ / ___ / _____
☐ Son ☐ Daughter	☐ Yes ☐ 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? Yes ☐ No ☐ If yes, please list details.	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**. 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 First Name MI Last Name	Provider No.	Current Patient
Self: ☐ Male ☐ Female				☐ Yes ☐ No
☐ Husband ☐ Wife ☐ Domestic Partner				☐ Yes ☐ No
☐ Son ☐ Daughter				☐ Yes ☐ No
☐ Son ☐ Daughter				☐ Yes ☐ No
☐ Son ☐ Daughter				☐ Yes ☐ 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 (or legal guardian) | Today's Date (required) | Print Name (and relationship if subscriber is a minor)

X _____ _____/_____/_____ _____

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

X _____ _____/_____/_____ _____

Signature of Family Member Age 18 and Over (if applicable) | Today's Date (required) | Print Name

X _____ _____/_____/_____ _____

Signature of Family Member Age 18 and Over (if applicable) | Today's Date (required) | Print Name

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 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