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

blue of california

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-DS).
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 629013, El Dorado Hills, CA 95762-9013. Or fax it to (916) 350-7500. Please do not include dues/premiums.

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

Active Start℠ plans*	**Shield Spectrum PPO℠ plans**	**Shield Savings℠ plans**	**Vital Shield℠ plans*,1**
☐ 25 ☐ 25 Generic Rx[1] ☐ 35 ☐ 35 Generic Rx[1]	☐ PPO Plan 500 ☐ PPO Plan 1500	☐ 1800/3600*,1	☐ 900 ☐ 2900
Access+ plans ☐ HMO ☐ Value HMO	☐ PPO Plan 750 ☐ PPO Plan 2000	☐ 2400/4800	**Vital Shield℠ Plus plans*,1**
Balance℠ plans*,1 ☐ 1000 ☐ 1700 ☐ 2500	☐ PPO Plan 5000*	☐ 3500*,1	☐ 400 ☐ 400 Generic Rx
Essential℠ plans* ☐ 1750[1] ☐ 3000 ☐ 4500	☐ Blue Shield Life PPO Plan 1500*	☐ 4000/8000*	☐ 900 ☐ 900 Generic Rx
	☐ Blue Shield Life PPO Plan 2000*	☐ 5200*,1	☐ 2900 ☐ 2900 Generic Rx

☐ **Bridge Plan***,1 (hospital insurance indemnity rider – available for Shield Savings 3500, 4000/8000, and 5200)

☐ 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 Smile℠ 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 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: ☐ Yes ☐ No	Work phone No.	Home phone No.		Social Security No.
Domestic partner: ☐ Yes ☐ No				

☐ 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	

To help us serve you better in the future, please indicate your language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese

Does the subscriber understand English? ☐ Yes ☐ No ☐ Other: _____

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

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 plan at child* rate	First name	MI	Last name (if different from above)	Social Security No.	Date of birth Mo./Day/Yr.
Self: ☐ Male ☐ Female	N/A				_____ – _____ – _____	___ / ___ / _____
☐ Husband ☐ Wife	N/A				_____ – _____ – _____	___ / ___ / _____
Domestic partner: ☐ Male ☐ Female	N/A				_____ – _____ – _____	___ / ___ / _____
☐ Son ☐ Daughter	☐ Yes ☐ No				_____ – _____ – _____	___ / ___ / _____
☐ Son ☐ Daughter	☐ Yes ☐ No				_____ – _____ – _____	___ / ___ / _____
☐ Son ☐ Daughter	☐ Yes ☐ No				_____ – _____ – _____	___ / ___ / _____

* Under age 19

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 or hospitalization within the past two years? **Yes** ☐ **No** ☐

Name(s) of family member(s)	Condition(s) diagnosed	Type(s) of treatment(s) received	Date treatment(s) began ___ / ___ / ___	Date treatment(s) 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(s) 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(s) of family member(s)	Name(s) of medication(s)	Reason(s) for prescription(s)

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

5. Are you, or any family member, expecting a child with anyone, even if the expecting mother is not listed on this form? **Yes** ☐ **No** ☐

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

6. 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(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 – 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, contact your broker or call Blue Shield at **(800) 431-2809**.

Relationship	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	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 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 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 TESTING PROHIBITED: 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 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 broker, the broker must complete the section below.

Broker No.	Telephone No.	Fax No.
Broker name		
Broker address		
City	State	ZIP code
E-mail address		

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

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.