



## SUBSCRIBER IFP PLAN CHANGE REQUEST FORM

### INSTRUCTIONS:

Form must be typed or completed in blue or black ink. Do not include dues/premiums. You can use this form to transfer YouthCare subscribers as well as adult subscribers. Your spouse or Domestic Partner (under age 65), and dependent children (under age 19, or under age 23 if a full-time student) who are neither married nor in a domestic partnership, are eligible to apply for dependent coverage. Form C12900-AE is required when coming from a Blue Shield Group Health Plan, Guaranteed Issue Plan, Individual Conversion Plan or Post-MRMIP Graduate Product coverage, or if you would like to add a new family member or domestic partner to your plan. Call Blue Shield at **(800) 431-2809** or contact your agent or broker for help filling out this form. Please send your completed form to: Blue Shield, P.O. Box 629013, El Dorado Hills, CA 95762-9013. Or fax it to **(916) 350-7500**.

### Part 1 A. – INDICATE THE NEW HEALTH PLAN YOU ARE REQUESTING:

CHOOSE HEALTH PLAN (CHECK ONE BOX ONLY):	<input type="checkbox"/> ACTIVE START PLAN 35* <input type="checkbox"/> ACTIVE START PLAN 25* <input type="checkbox"/> ESSENTIAL PLAN 3000*. <sup>1</sup> <input type="checkbox"/> ESSENTIAL PLAN 4500*. <sup>1</sup>	<b>SHIELD SPECTRUM PPO PLANS</b> <input type="checkbox"/> PPO PLAN 500 <input type="checkbox"/> PPO PLAN 1500 <input type="checkbox"/> PPO PLAN 750 <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 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 PLAN</b> <input type="checkbox"/> ACCESS+ HMO PLAN <input type="checkbox"/> ACCESS+ VALUE HMO PLAN
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\* UNDERWRITTEN BY BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY.

<sup>1</sup> PENDING REGULATORY APPROVAL.

### Part 1 B. – UNBUNDLE

CHECK HERE IF YOU ARE REQUESTING TO SPLIT INDIVIDUALS INTO SEPARATE CONTRACTS.

Please list family members to separate and indicate the plan they wish to change to:

Family Member Name \_\_\_\_\_ Plan \_\_\_\_\_

Do the remaining family members wish to stay on their current plan?  YES  NO

### Part 1 C. – TIER RECONSIDERATION

CHECK HERE IF YOU ARE REQUESTING TIER RECONSIDERATION.

### Part 2 – 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**

If Dental HMO: Dental Provider #: \_\_\_\_\_

If Dental HMO: Dental Provider Name: \_\_\_\_\_

Dental HMO only: You must choose a Dental Provider from the Blue Shield Dental HMO Dental Provider Directory, available at [www.mylifepath.com](http://www.mylifepath.com), or call **(800) 431-2809**. The Dental Provider you choose will provide or arrange dental care for you and all covered dependents.

### Part 3 – SUBSCRIBER INFORMATION

BLUE SHIELD SUBSCRIBER #	FIRST NAME	MI	LAST NAME
MARRIED <input type="checkbox"/> YES <input type="checkbox"/> NO	DOMESTIC PARTNER <input type="checkbox"/> YES <input type="checkbox"/> NO	HOME PHONE #	WORK PHONE #
SOCIAL SECURITY NUMBER			

CHECK HERE IF THIS IS A NEW ADDRESS

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ COUNTY OF RESIDENCE \_\_\_\_\_

BILLING ADDRESS (IF DIFFERENT FROM ABOVE) \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

MAILING ADDRESS (IF DIFFERENT FROM ABOVE) \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

**Part 4 – LIST ALL CURRENTLY ENROLLED MEMBERS REQUESTING A PLAN CHANGE**

RELATIONSHIP	CONSIDER FOR SEPARATE YOUTHCARE	FIRST NAME	MI	LAST NAME (IF DIFFERENT FROM ABOVE)	SOCIAL SECURITY #	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. 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.**

**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):	CONDITION(S) DIAGNOSED:	NAME OF MEDICATION(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 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 HMOs**

The Blue Shield HMOs are available only in those Plan Service Areas specified in the Blue Shield HMO Physician and Hospital Directory, available at [www.mylifepath.com](http://www.mylifepath.com). Subscriber must live or work in a Plan Service Area. You must 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 #	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
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SPOUSE’S/DOMESTIC PARTNER’S OCCUPATION AND EMPLOYER	EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
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**Part 7 – AUTHORIZATIONS, TERMS & CONDITIONS**

In addition to the terms & 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.

