Blue Cross and Blue Shield of North Carolina, the North Carolina State Health Plan and North Carolina HealthSmart are not affiliated. Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

CHANGE FORM

CURRENTLY I AM IN THE: ☐ INDEMNITY PLAN ☐ PPO PLAN

PLEASE TYPE OR PRINT CLEARLY. DO NOT WRITE IN SHADED AREAS.

1. SUBSCRIBER/MEMBER ID NO. | SOCIAL SECURITY NUMBER | LAST NAME | FIRST | INITIAL | PLEASE SEND ID CARD ☐

2. ☐ **CHANGE MY ADDRESS TO** STREET - ROUTE NO./BOX NO. | CITY | STATE | ZIP | COUNTY

3. ☐ **NAME CHANGE** LAST NAME | FIRST | INITIAL | BECAUSE OF ☐ MARRIAGE ☐ LEGAL CHANGE | ☐ **HOME PHONE NUMBER** — —

4. ☐ **CORRECT MY BIRTHDATE TO** MO. | BIRTHDATE DATE | YEAR | ☐ **CHANGE MY MARITAL STATUS TO** ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ MARRIED ☐ WIDOWED | **CANCEL COVERAGE** ☐ I WISH TO CANCEL COVERAGE.

5. ☐ **CHANGE MY COVERAGE TO** ☐ EMPLOYEE ONLY ☐ EMPLOYEE-CHILD/REN ☐ EMPLOYEE-SPOUSE (PPO Only) ☐ EMPLOYEE-FAMILY | **COMPLETE IF YOUR SPOUSE IS A TEACHER OR STATE EMPLOYEE** NAME OF SPOUSE | ID NUMBER

6. ☐ **REMOVE, CHANGE OR ADD DEPENDENTS**

☐ REMOVE / ☐ CHANGE / ☐ ADD MY ☐ SPOUSE / ☐ DEPENDENT CHILD/REN

REASON AND DATE OF EVENT REQUIRED

☐ MARRIAGE	___/___/___	☐ STUDENT	___/___/___	☐ FMLA/MILITARY	___/___/___
☐ SEPARATION	___/___/___	☐ NEWBORN	___/___/___	☐ NO LONGER STUDENT	___/___/___
☐ DIVORCE	___/___/___	☐ STEPCHILD	___/___/___	☐ MAXIMUM STUDENT AGE 26	___/___/___
☐ DEATH	___/___/___	☐ FOSTER CHILD	___/___/___	☐ MAXIMUM CHILD AGE 19	___/___/___
				☐ OTHER ________	

7. ☐ **REMOVE DEPENDENTS** ADDRESS (IF DIFFERENT FROM YOURS) STREET - ROUTE NO./BOX NO. | CITY | STATE | ZIP | COUNTY

DEPENDENT INFORMATION → List dependents to be added or removed. List additional children to be added on a separate form.

	NAME (First, Middle Initial, Last)	SOCIAL SECURITY NUMBER	BIRTHDATE	SEX	CHILD IS MY	COMPLETE ONLY IF CHILD IS OVER 19	MEDICARE ELIGIBLE?	DOES WAITING PERIOD APPLY?
8. ☐ REMOVE ☐ ADD	SPOUSE		MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE			☐ YES (see lines 13 & 14) ☐ NO	☐ YES ☐ NO
9. ☐ REMOVE ☐ CHANGE ☐ ADD	CHILD 1		MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE	☐ NATURAL ☐ FOSTER ☐ ADOPTED ☐ STEP	☐ STUDENT (see line 12) ☐ HANDICAPPED	☐ YES (see lines 13 & 14) ☐ NO	☐ YES ☐ NO
10. ☐ REMOVE ☐ CHANGE ☐ ADD	CHILD 2		MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE	☐ NATURAL ☐ FOSTER ☐ ADOPTED ☐ STEP	☐ STUDENT (see line 12) ☐ HANDICAPPED	☐ YES (see lines 13 & 14) ☐ NO	☐ YES ☐ NO
11. ☐ REMOVE ☐ CHANGE ☐ ADD	CHILD 3		MONTH DAY YEAR / /	☐ MALE ☐ FEMALE	☐ NATURAL ☐ FOSTER ☐ ADOPTED ☐ STEP	☐ STUDENT (see line 12) ☐ HANDICAPPED	☐ YES (see lines 13 & 14) ☐ NO	☐ YES ☐ NO

12. IF FULL-TIME STUDENT, LIST DEPENDENT'S NAME AND ACCREDITED INSTITUTION.

MEDICARE INFORMATION List below yourself and any other persons to be covered who are eligible for Part A and/or B of Medicare.

	NAME	MEDICARE CLAIM NUMBER	ENTITLED DUE TO:	EFFECTIVE DATE ENROLLED	
13.			☐ AGE ☐ DISABILITY ☐ RENAL DISEASE	PART A (MM/DD/YY): ___/___/___	PART B (MM/DD/YY): ___/___/___
14.			☐ AGE ☐ DISABILITY ☐ RENAL DISEASE	PART A (MM/DD/YY): ___/___/___	PART B (MM/DD/YY): ___/___/___

15. ☐ **OTHER GROUP HEALTH COVERAGE** COMPLETE THE PRIOR COVERAGE/OTHER COVERAGE INFORMATION FORM IF YOU OR YOUR DEPENDENTS HAVE OTHER GROUP HEALTH COVERAGE IN EFFECT, OR IF YOU OR YOUR DEPENDENTS HAD OTHER COVERAGE THAT ENDED WITHIN THE PAST 63 DAYS. ☐ NO ☐ YES

16. COMMENTS

EMPLOYEE AUTHORIZATION

I hereby apply for the changes, adjustments and/or additions to my enrollment listed on the form above and I agree that all information provided is correct. I further agree that we shall abide by the provisions of the Agreement for the selected plan option.

I hereby authorize my employer to deduct from my earnings any deduction for the coverage elected above.

DESIRED EFFECTIVE DATE OF CHANGE ______ MONTH 01 DAY ______ YEAR

EMPLOYEE'S SIGNATURE ____________________ DATE SIGNED ____________

EMPLOYING UNIT MUST COMPLETE

EMPLOYING UNIT NAME	EXPEDITE? ☐ NO ☐ YES
GROUP NO.	HIRE DATE
PAYROLL NO.	DEPARTMENT NO.
DOES MEDICARE REDUCED RATE APPLY?	☐ NO ☐ YES
EMPLOYEE DEDUCTION $	EFFECTIVE DATE
EMPLOYER CONTRIBUTION $	01

 PINK COPY should be retained by the employee and used as a temporary ID card   Submit WHITE and YELLOW COPY to employing unit

INSTRUCTIONS TO COMPLETE THE CHANGE FORM

Top of Form Check the Plan in which you are currently enrolled.

Line 1 Fill in your member ID number or social security number and name. If you need a new ID card, check the "please send ID card" box.

Line 2 If your address has changed; fill in your correct address.

Line 3 If your name has changed; fill in your correct name and check the reason for your name change. Fill in your home phone number.

Line 4 Fill in your correct date of birth and marital status. If you wish to cancel coverage, check the "I wish to cancel coverage" box.

Line 5 If you desire to change your coverage, select the coverage you are choosing. If your spouse is an active or retired teacher or State employee, give your spouse's name and member ID number.

Line 6 If you are removing or adding dependents, check "remove" or "add". If you are changing the status of a currently covered dependent child to a student, check the "change" box. Check the event that occurred that allows the change and provide the date of the event.

Line 7 If you are removing dependents and the dependent's address is different from yours, fill in the dependent's address.

Lines 8 through 11 If you are removing dependents, check "remove" and list the dependent's name(s) to be removed.

If you are adding your spouse, check "add" on line 8 and provide his/her first name, middle initial, last name and social security number. Enter his/her date of birth and sex. Check "yes" or "no" to indicate whether he/she has Medicare. If "yes" is checked, complete line 13 or 14.

If you are adding a child or children, check "add" on line 9 through 11, as applicable, and provide each eligible dependent child's name, middle initial, last name and social security number. Enter your child's date of birth, sex and relationship to you. Complete a Certification of Dependent Eligibility Form for each foster child (available from your Health Benefits Representative)and attach it to this form.

If you have a child over 19 who is a full-time student, check "student". If you have a child over 19 who is mentally or physically incapacitated, check "handicapped" and complete a Coverage Request for Mentally or Physically Incapacitated Children (available from your Health Benefits Representative) and attach it to this form.

Check "yes" or "no" to indicate whether your child is eligible for Medicare. If "yes" is checked, complete line 13 or 14.

If you want to change the status of a child to a student, check "change" on lines 9 through 11, as applicable, provide the child's name and complete line 12.

Your Health Benefits Representative will complete the waiting period information.

Line 12 If you checked "student" for any dependent child(ren) to be enrolled on lines 9 through 11, give the dependent's name and the name of the accredited institution that the dependent is attending.

Line 13 and 14 If you, your spouse, or any of your children to be enrolled are eligible for Medicare, give the name, Medicare claim number, reason for Medicare eligibility, and the dates enrolled in Part A and Part B.

Line 15 Check "yes" or "no" to indicate whether any participant listed to be covered has other employer-sponsored group health coverage. If "yes" is checked, complete the Prior Coverage /Other Coverage Information Form (available from your Health Benefits Representative). Attach it to this form.

Employee Authorization Read this statement, sign and date the form. Return the form to your Health Benefits Representative. If you have questions about this form, contact your Health Benefits Representative or Customer Service at **1-888-234-2416** if you selected one of the PPO Plans; or **1-800-422-4658** if you selected the Indemnity Plan.

Your Health Benefits Representative will complete the remaining information.