Excellus | National strength. Local focus. Individual care.

A nonprofit independent licensee of the Blue Cross Blue Shield Association

# Member Change Form

- Please print clearly and complete all sections that apply to you
- Additional instructions are included

## Section 1: Subscriber Information (Please refer to your ID card)

Subscriber Name _____

Subscriber ID _____

_____

Street Address City State Zip


## Section 2: Please complete this section if you need to add someone to your plan (choose one)

☐Spouse/Domestic Partner ☐ Dependent ☐Disabled Dependent ☐Child Only

Effective Date _____

**Dependent Information:**

_____ _____

Last Name First Name MI Social Security #*

Sex: M F Birthdate ___/___/___

## Section 3: Please complete this section if you need to remove someone from your plan (choose one)

☐Spouse/Domestic Partner ☐ Dependent ☐Disabled Dependent ☐Child Only

Effective Date _____

**Dependent Information:**

_____ _____

Last Name First Name MI Social Security #*

Sex: M F Birthdate ___/___/___

## Section 4: Please complete this section if you need to cancel your health insurance policy

Effective Date: _____

Why are you canceling this policy?

_____

## Section 5: Special Enrollment Period

If you are applying outside of the annual Open Enrollment Period, please check one of the events below that applies to you. The Special Enrollment Period begins on the date of the event checked and continues for 60 days.

☐Loss of coverage ☐Marriage ☐Birth ☐Adoption ☐Domestic Partnership ☐Death
☐A move in or out of service area ☐Divorce, annulment or legal separation ☐Change in employment status
☐Dependent reaches maximum age of coverage ☐Change to new employer that does not offer insurance

Date of Event _____

**Please mail change form to:**

Excellus BlueCross BlueShield
P.O. Box 22999
Rochester, NY 14692

If you have questions, please contact our dedicated Insurance Advisors at 1-877-626-9298
Learn about exclusive member benefits at ExcellusBCBS.com/FindAPlan

## Section 6: Release – You must sign and date this form to be eligible for health insurance.

Pursuant to federal rules that implement the Affordable Care Act, individual health insurance policies must be written on a calendar year basis beginning in 2015. This means that, for 2015 coverage, if your effective date of coverage is a date later than January 1st, the initial term of coverage for your policy will be for less than a full year and will end on December 31, 2015. Please be advised that all benefits and cost sharing under your policy, including the full annual deductible, apply to the partial year of coverage.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation, I have thoroughly read, understand and agree to comply with the terms of the release on the back.

**Subscriber Signature**_____
**Date**_____

# Change Form Instructions

## When to use the change form

- To add a member to an existing health insurance plan. There are times when you may be eligible to add a dependent to your policy other than during Open Enrollment. These times, are called Special Enrollment Periods (SEP). Examples of an SEP include having a baby or getting married. SEPs are explained in your Member Contract. Once a special enrollment period has been begun; you have 60 days to add a dependent to your policy.

- To remove a dependent or terminate your coverage: You may remove a dependent(s) from your policy or terminate your policy at any time by giving us at least 14 days prior written notice. This form may be considered written notice.

**When NOT to use the change form:**

- If you would like to change your plan or the type of coverage you have elected; please use the "Individual & Family Health Insurance Application."

**Section 1:**

Please include accurate information in this section. This could affect the processing of your application and/or claims. Provide your complete First and Last name, subscriber ID, address and date of birth. Refer to the information on your membership identification card (as shown).

**Section 2:**

If you are adding a dependent to your plan, please indicate the date you would like the coverage to begin. Then select the type of dependent you would like to add. Please provide the dependent's name, social security number, gender and date of birth. If you are adding a spouse, domestic partner, disabled dependent, adopted child or person for whom you are the legal guardian, please attach the appropriate documentation as described in the "when to use this form section" above.

*We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

**Section 3:**

If you are removing a dependent, please indicate the date you would like the coverage to end. Provide the dependent's name, social security, gender and date of birth.

*We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

**Section 4:**

If you are cancelling the policy and all members enrolled under the policy; please provide the date you would like the coverage to end and the reason for cancelling.

**Section 5:**

There are certain life changes that make you eligible for a Special Enrollment Period (SEP) such as having a baby, getting married or your coverage under another plan is ending. Select the event that applies to you and include the date of the event. You may be required to provide documentation of certain events. *Please contact our dedicated Insurance Advisors at 1-877-626-9298 for a list of documentation required.

**Section 6:**

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who now or in the future accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).

I hereby accept responsibility for payment of any portion of the premium.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

**EXCLUSIVE PROVIDER ORGANIZATION (EPO)**

I understand that if I elect Exclusive Provider Organization (EPO) coverage, except in an emergency, all care must be provided by medical providers who participate with the EPO and I will not receive benefits for care that I receive from providers who do not participate with the EPO.

**PREFERRED PROVIDER ORGANIZATION (PPO)**

I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.