MEMBER CHANGE FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY IN BLUE OR BLACK INK. DO NOT USE PENCIL OR HIGHLIGHTER.

EMPLOYEE/CONTRACT HOLDER INFORMATION

Effective Date	Employer/Group Name	Group Number	Payroll Location

REASON FOR COMPLETION:
- ❑ Enrollment Changes
- ❑ Cancel Entire Contract
- ❑ COBRA Continuant
  Start Date ____________
  (Please attach a copy of COBRA Election Notice.)

DEPENDENT CHANGES:
Add dependent(s) due to HIPAA Life Event:
❑ Birth ❑ Marriage ❑ Adoption ❑ Other ____________
Date of Above Event ____________
(Please attach a copy of HIPAA Certification Form.)
Cancel dependents due to:
❑ Divorce ❑ Death ❑ Other ____________
Date of Above Event ____________

OTHER CHANGES:
- ❑ New Name
- ❑ New Address
- ❑ Change to Medicare Eligible
- ❑ Change Coverage

Date of Above Event ____________

CANCEL Reason for Contract Holder:
❑ Deceased ❑ Left Employment ❑ Involuntary Lay-Off ❑ Other Coverage ❑ Other ____________ Date of Above Event ____________

Additional Comments:

First Name	MI	Last Name	Home/Cell Phone

Address	City	State	Zip	County

Date of Birth *(Month/Day/Year)*	Age	Gender	Employment Status	Social Security Number *(If no SS#, write N/A)*
/ /		❑ Male ❑ Female	❑ Active ❑ COBRA ❑ Disabled	

Product Selection(s)

❑ Medical Product Name ____________ ❑ Vision ❑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
		❑ Yes ❑ No

COVERED DEPENDENT INFORMATION (If additional space is required, attach a separate sheet)

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You?
			❑ Spouse ❑ Domestic Partner†

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age
	❑ Male ❑ Female	/ /	

Product Selection(s)

❑ Medical ❑ Vision ❑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Spouse/DP an Established Patient?
		❑ Yes ❑ No

Note: If spouse's last name differs from the contract holder above, please attach a copy of your marriage certificate.
†If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and financial verification documents to this application.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You?
			❑ Child ❑ Step-child ❑ Adopted* ❑ Other*

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age
	❑ Male ❑ Female	/ /	

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Child an Established Patient?
		❑ Yes ❑ No

If Over Age 25, is Dependent Disabled?	Product Selection(s)
❑ Yes ❑ No	❑ Medical ❑ Vision ❑ Dental

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custody/legal papers to support dependent eligibility.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Adopted* ❑ Other*	
Social Security Number *(If no SS#, write N/A)*		Gender ❑ Male ❑ Female	Date of Birth *(Month/Day/Year)* / /	Age
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? ❑ Yes ❑ No	
If Over Age 25, is Dependent Disabled? ❑ Yes ❑ No		Product Selection(s) ❑ Medical ❑ Vision ❑ Dental		

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Adopted* ❑ Other*	
Social Security Number *(If no SS#, write N/A)*		Gender ❑ Male ❑ Female	Date of Birth *(Month/Day/Year)* / /	Age
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? ❑ Yes ❑ No	
If Over Age 25, is Dependent Disabled? ❑ Yes ❑ No		Product Selection(s) ❑ Medical ❑ Vision ❑ Dental		

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custody/legal papers to support dependent eligibility.

OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	**Group Number**	**Effective Date** / /	**Name of Policyholder**
Policyholder Date of Birth / /	**Relationship to Policyholder**	**Policy Number**	**Policyholder Employment Status** ❑ Active ❑ Retired Date of Retirement: / /

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	**Health Insurance Claim Number**	**Effective Dates**			**Check (✓) Reason For Medicare Coverage**			**Medicare Supplement or Complement?**
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								❑ Yes ❑ No
								❑ Yes ❑ No
								❑ Yes ❑ No

IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

I understand that this form enrolls those eligible persons listed above in the Product as described in the agreement between Highmark and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered. To the best of my knowledge and belief, the information provided on this application is true and correct.

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 subjects such person to criminal and civil penalties.

Employee/Contract Holder Signature **Date**

Please fax Member Change Forms to (800) 290-3301 or mail the forms to the following address:

Membership Department • P.O. Box 535193 • Pittsburgh, PA 15253-5193

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, First Priority Life Insurance Company (FPLIC) or First Priority Health (FPH). Information is issued by Highmark Blue Cross Blue Shield on behalf of these companies, which are independent licensees of Blue Cross and Blue Shield Association.

Highmark Blue Cross Blue Shield, FPLIC and FPH do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

We are committed to providing outstanding services for our applicants and members. If you require special assistance, including accommodations for disabilities or limited English proficiency, please call the number on the back of your member ID card to request these free services (TTY/TDD users may call 711).

Estamos comprometidos a ofrecer servicios excepcionales a nuestros solicitantes y miembros. Si usted necesita ayuda especial, incluyendo acomodaciones para discapacidades o dominio limitado del inglés, por favor llame al número que aparece en su tarjeta de identificación para solicitar este servicio gratuito. Usuarios de TTY con problemas de audición pueden llamar al 711 para recibir ayuda de forma gratuita.

我們致力於為我們的申請人和會員們提供卓越的服務。如果您需要特殊協助，如英語能力有限，請撥打您證件上的號碼，來要求這些免費服務。如您有聆聽障礙需要TTY免費服務，請致電711。

May pananagutan kaming magbigay ng bukod-tanging mga serbisyo para sa aming mga aplikante at mga miyembro. Kung kailangan mo ng espesyal na tulong, kabilang ang akomodasyon para sa limitadong kahusayan sa wikang Ingles pakitawagan ang numero sa iyong ID card para hilingin ang libreng serbisyong ito. Ang mga gumagamit ng TTY para sa mga may kapansanan sa pagdinig ay maaaring tumawag sa 711 para makatanggap ng libreng tulong.

Nihinaanish niizhónîgo bee nihiká’ adiilwołígíí binahji’ ts’ídá yéego bidiilkaal, nihî naaltsoos nidahonílígíí dóó Bee Atah ídlínígíí nihił hada’dít’éhígíí nihá. T’áá hait’éego da níntł’ago níká’ iidoowoł, díí Bilagáana Bizaad doo hózhǫ́ bik’i’ diitiihgó, ei Bik’isíndáago bee néého̜zínígíí béésh bee hane’é bikáá’, t’áá jíík’eh áká’aná’áwo’, éí bich’į’ hodíílni. Doo hazhó’ó azhdiits’a’gó éí TTY chodayooł’ínígíí 711 bich’į’ hodíílnih, t’áá jíík’eh níká’iidoowoł.