



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
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REASON FOR COMPLETION: <input type="checkbox"/> Enrollment Changes <input type="checkbox"/> Cancel Entire Contract <input type="checkbox"/> COBRA Continuant Start Date _____ <i>(Please attach a copy of COBRA Election Notice.)</i>	DEPENDENT CHANGES: Add dependent(s) due to HIPAA Life Event: <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption <input type="checkbox"/> Other _____ Date of Above Event _____ <i>(Please attach a copy of HIPAA Certification Form.)</i> Cancel dependents due to: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other _____ Date of Above Event _____	OTHER CHANGES: <input type="checkbox"/> New Name <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage Date of Above Event _____
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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
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Address	City	State	Zip	County
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Date of Birth (Month/Day/Year) / /	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Employment Status <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Disabled	Social Security Number (If no SS#, write N/A)
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No
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COVERED DEPENDENT INFORMATION (If additional space is required, attach a separate sheet)

SPOUSE/DOMESTIC PARTNER

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

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Over Age 25, is Dependent Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		Product Selection(s) <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> 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 <input type="checkbox"/> Active <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> 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 Delaware 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 one of the following addresses:

<https://www.enrollmentandbilling@highmark.com>

Membership Department
P.O. Box 890172
Camp Hill, PA 17089-0172

Highmark Blue Cross Blue Shield Delaware is an independent licensee of Blue Cross and Blue Shield Association.

To find more information about Highmark Delaware's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to [DiscoverHighmark.com/QualityAssurance](https://www.discoverhighmark.com/QualityAssurance); or for a paper copy, call 1-855-873-4108.

Highmark Blue Cross Blue Shield Delaware does 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.

Health care plans are subject to terms of the benefit agreement.

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 niizhónigo bee nihiká' adiiwofigíi binahjí' ts'ídá yéego bidiilkaal, nihí naaltsoos nidahoníngíi dóo Bee Atah ídlinígíi nihít hada'dít' éhígíi nihá. T'áá hait'éego da nint'ago níká' iidoowot, díi Bilagáana Bizaad doo hózq' bki'iitiigó, ei Bik'íindáago bee nééhózingíi éesh bee hane' é bikáá', t'áá jík'eh áká'aná'áwo', éi bich'j' hodílni. Doo hazhó'ó azhdiits'a'gó éi TTY chodayool'ínigíi 711 bich'j' hodílnih, t'áá jík'eh níká'iidoowot.