Small Business subscriber change request

Effective January 1, 2025

Blue Shield of California and
Blue Shield of California Life & Health Insurance Company

All change requests must be received within 31 days of the effective date of the change. This form is used to request changes in personal information, add/cancel dependent coverage, or change plans during open enrollment. For employees requesting a new primary care physician (HMO plans), visit **blueshieldca.com** or call Blue Shield at the number on the back of your Blue Shield member ID card.

Which changes are you making? (select all that apply)

- ☐ Subscriber address
- ☐ Phone/email address change
- ☐ Subscriber name change
- ☐ Date of birth
- ☐ Social Security number
- ☐ Dependent name change
- ☐ Dependent address change
- ☐ Dependent addition coverage
- ☐ Effective date update
- ☐ Date of hire
- ☐ Waiving employee coverage
- ☐ Waiving dependent coverage
- ☐ Plan change

Special Enrollment Period

If you are making enrollment or coverage changes during a Special Enrollment Period, enter the qualifying event: _____
Date of qualifying event: _____

Subscriber information – All information requested in this section is required for all changes.

Enrolled employee (subscriber) name

Blue Shield subscriber ID number

Social Security number (required per CMS)

Employment status ☐ Full time (30 hrs) ☐ Part time (20-29 hrs) ☐ COBRA/Cal-COBRA beneficiary

Group/employer name

Blue Shield Group ID (from ID card)

Requested effective date

Please tell us about yourself. How would you describe your race or ethnicity? These race and ethnicity questions are optional and are only used to help ensure all members have the same access to the highest quality of care.

1. Are you of Hispanic or Latino origin?
   - ☐ Yes
   - ☐ No
   - ☐ Unknown
   - ☐ Declined
2. If yes, please select one:
   - ☐ Cuban
   - ☐ Guatemalan
   - ☐ Mexican, Mexican American, Chicano
   - ☐ Puerto Rican
   - ☐ Salvadoran
   - ☐ 2 or more Ethnicities
   - ☐ Other Hispanic, Latino, Spanish
3. Which race(s) do you identify with? (select one)
   - ☐ American Indian or Alaska Native
   - ☐ Asian Indian
   - ☐ Black or African American
   - ☐ Cambodian
   - ☐ Chinese
   - ☐ Filipino
   - ☐ Guamanian or Chamorro
   - ☐ Hmong
   - ☐ Japanese
   - ☐ Korean
   - ☐ Laotian
   - ☐ Native Hawaiian
   - ☐ Samoan
   - ☐ Vietnamese
   - ☐ White
   - ☐ 2 or more Races
   - ☐ Other
   - ☐ Unknown
   - ☐ Declined

Member information update

Address change

Please complete this section to update your address. Include both your full previous address and full new address. HMO plans: If you have moved outside your primary care physician's service area, you will need to change your primary care physician. Visit **blueshieldca.com**, or call Blue Shield at the number on your ID card for more information.

Old address | City | State | ZIP code | County

New address | City | State | ZIP code | County

Dependent name (if address change is applicable for dependent only):

Phone/email address change

Please complete this section to update your phone or email address information with Blue Shield.

Old phone number ☐ Cell ☐ Landline | Old email address

New phone number ☐ Cell ☐ Landline | New email address

Subscriber name | Subscriber ID number | Group/employer name

Employee name change – documentation may be required
Note: A copy of court order, marriage license, driver's license, or ID card are examples of required documentation.

Prior name (first name, last name) | New name (first name, last name)

Reason for change: ☐ Marriage ☐ Divorce ☐ Other (please specify): | Documentation attached? ☐ Yes ☐ No

Date of birth correction – documentation required
Note: A copy of the driver's license, ID card, or birth certificate are examples of required documentation.

Member's name | Date of birth | Documentation attached? ☐ Yes ☐ No

Social Security number correction/change – documentation required
A copy of the Social Security card, letter of verification from the Social Security Office, and a written statement explaining the reason for the change are examples of required documentation.

Old Social Security number | New Social Security number | Documentation attached? ☐ Yes ☐ No

Member eligibility changes

Dependent addition of coverage
Please complete this section to add a spouse, domestic partner, or dependent child to the employee's coverage. Please copy and attach additional pages as needed if adding multiple dependents. The request must be received within the time frame allowed per the qualifying event, or during the group's open enrollment period. Documentation may be required to verify the date of the qualifying event, including for loss of coverage, adoption, or court-ordered coverage. A completed **Refusal of Coverage (C19927)** is required for any dependent that is refusing coverage under the plan.
Note: Social Security number is required per CMS.

Dependent 1

Relationship to employee
☐ Dependent child
☐ Spouse/domestic partner
☐ Dependent child: legal guardianship

Reason for addition
☐ Newborn
☐ Adoption
☐ Court order*
☐ Marriage
☐ Domestic partnership
☐ Loss of coverage
☐ Open enrollment
☐ Other qualifying event (specify)

* Court order required.

Qualifying event date:

Social Security number | Date of birth | Gender: ☐ Male ☐ Female

Which race does this dependent identify with?

Which ethnicity does this dependent identify with?

First name | MI | Last name | Suffix

Address (if different from employee) | City | State | ZIP code

Was the dependent covered under another health insurance plan within the past 12 months? ☐ Yes ☐ No
If yes, please specify carrier and plan name, start and end dates of coverage:

Carrier and plan name: _____ _____ to _____

HMO provider name | HMO provider number | IPA/MG name | Current patient? ☐ Yes ☐ No

Dental HMO provider name | Dental HMO provider number | Current patient? ☐ Yes ☐ No

Enrolling in same products selected by subscriber? ☐ Yes ☐ No If no, please attach completed Refusal of Coverage form.

Subscriber name | Subscriber ID number | Group/employer name

Dependent 2

Relationship to employee
☐ Dependent child
☐ Spouse/domestic partner
☐ Dependent child: legal guardianship

Reason for addition
☐ Newborn
☐ Adoption
☐ Court order*
☐ Marriage
☐ Domestic partnership
☐ Loss of coverage
☐ Open enrollment
☐ Other qualifying event (specify)

* Court order required.

Qualifying event date: _____

Social Security number | Date of birth | Gender: ☐ Male ☐ Female

Which race does this dependent identify with?

Which ethnicity does this dependent identify with?

First name | MI | Last name | Suffix

Address (if different from employee) | City | State | ZIP code

Was the dependent covered under another health insurance plan within the past 12 months? ☐ Yes ☐ No
If yes, please specify carrier and plan name, start and end dates of coverage:

Carrier and plan name: _____ _____ to _____

HMO provider name | HMO provider number | IPA/MG name | Current patient? ☐ Yes ☐ No

Dental HMO provider name | Dental HMO provider number | Current patient? ☐ Yes ☐ No

Enrolling in same products selected by subscriber? ☐ Yes ☐ No | If no, please attach completed Refusal of Coverage form.

Dependent cancellation of coverage

Please complete this section to cancel all Blue Shield coverage for a dependent spouse, domestic partner, or child due to loss of eligibility. If any dependents being cancelled remain eligible for coverage, or if coverage is being partially cancelled (not all plans), a completed Refusal of Coverage form is required for those plans being declined/cancelled.

Relationship to employee
☐ Dependent child
☐ Spouse/domestic partner

Reason for cancellation
☐ Divorce ☐ Death
☐ Military deployment
☐ Other insurance coverage
☐ Termination of domestic partnership

Event date

Social Security number | Date of birth | Gender: ☐ Male ☐ Female

First name | MI | Last name | Suffix

Address (if different from employee) | City | State | ZIP code

Cancel coverage for all Blue Shield plans? ☐ Yes ☐ No | If no, please attach completed Refusal of Coverage form.

Relationship to employee
☐ Dependent child
☐ Spouse/domestic partner

Reason for cancellation
☐ Divorce ☐ Death
☐ Military deployment
☐ Other insurance coverage
☐ Termination of domestic partnership

Event date

Social Security number | Date of birth | Gender: ☐ Male ☐ Female

First name | MI | Last name | Suffix

Address (if different from employee) | City | State | ZIP code

Cancel coverage for all Blue Shield plans? ☐ Yes ☐ No | If no, please attach completed Refusal of Coverage form.

Subscriber name | Subscriber ID number | Group/employer name

Relationship to employee
☐ Dependent child
☐ Spouse/domestic partner

Reason for cancellation
☐ Divorce ☐ Death
☐ Military deployment
☐ Other insurance coverage
☐ Termination of domestic partnership

Event date

Social Security number | Date of birth | Gender: ☐ Male ☐ Female

First name | MI | Last name | Suffix

Address (if different from employee) | City | State | ZIP code

Cancel coverage for all Blue Shield plans? ☐ Yes ☐ No | If no, please attach completed Refusal of Coverage form.

Plan changes

Plan change request

Please indicate the requested changes to coverage through an annual or special open enrollment period by completing all sections below for medical plan and specialty plan options.

Medical benefit plans: Please check with your employer to determine the benefit plans available to you. ☐ **No change to medical benefits.**

Blue Shield of California Off-Exchange Package Plans

PPO plans – Full PPO Network

☐ Platinum Full PPO 0/0 OffEx
☐ Platinum Full PPO 0/10 OffEx
☐ Platinum Full PPO 250/10 OffEx
☐ Platinum Full PPO 250/15 OffEx
☐ Gold Full PPO 0/35 OffEx
☐ Gold Full PPO 500/30 OffEx
☐ Gold Full PPO 750/30 OffEx
☐ Gold Full PPO 1000/30 OffEx
☐ Silver Full PPO 1700/60 OffEx
☐ Silver Full PPO 2100/65 OffEx*
☐ Silver Full PPO 2350/70 OffEx
☐ Bronze Full PPO 4500/65 OffEx
☐ Bronze Full PPO 6250/65 OffEx
☐ Bronze Full PPO 6500/70 OffEx
☐ Bronze Full PPO 6850/55 OffEx
☐ Bronze Full PPO 7500/65 OffEx

HSA-compatible HDHP plans – Full PPO Network

☐ Gold Full PPO Savings 1750/15% HDHP PrevRx OffEx
☐ Silver Full PPO Savings 2300/30% OffEx
☐ Silver Full PPO Savings 2600/35% HDHP PrevRx OffEx
☐ Bronze Full PPO Savings 5700/40% OffEx
☐ Bronze Full PPO Savings 7500 OffEx

HSA-compatible HDHP plans – Tandem PPO Network

☐ Gold Tandem PPO Savings 1750/15% HDHP PrevRx OffEx
☐ Silver Tandem PPO Savings 2300/30% OffEx
☐ Silver Tandem PPO Savings 2600/35% HDHP PrevRx OffEx
☐ Bronze Tandem PPO Savings 5700/40% OffEx
☐ Bronze Tandem PPO Savings 7500 OffEx

Tandem PPO plans – Tandem PPO Network

☐ Platinum Tandem PPO 0/0 OffEx
☐ Platinum Tandem PPO 0/10 OffEx
☐ Platinum Tandem PPO 250/10 OffEx
☐ Platinum Tandem PPO 250/15 OffEx
☐ Virtual Blue℠ Platinum Tandem PPO 250/20 OffEx
☐ Gold Tandem PPO 0/35 OffEx
☐ Gold Tandem PPO 500/30 OffEx
☐ Gold Tandem PPO 750/30 OffEx
☐ Gold Tandem PPO 1000/30 OffEx
☐ Virtual Blue℠ Gold Tandem PPO 1500/45 OffEx
☐ Silver Tandem PPO 1700/60 OffEx
☐ Silver Tandem PPO 2100/65 OffEx*
☐ Silver Tandem PPO 2350/70 OffEx
☐ Virtual Blue℠ Silver Tandem PPO 2700/75 OffEx
☐ Bronze Tandem PPO 4500/65 OffEx
☐ Bronze Tandem PPO 6250/65 OffEx
☐ Bronze Tandem PPO 6500/70 OffEx
☐ Bronze Tandem PPO 6850/55 OffEx
☐ Bronze Tandem PPO 7500/65 OffEx
☐ Virtual Blue℠ Bronze Tandem PPO 7500/75 OffEx

Access+ HMO plans – Access+ HMO Network

☐ Platinum Access+ HMO® 0/20 OffEx
☐ Platinum Access+ HMO® 0/25 OffEx
☐ Platinum Access+ HMO® 0/30 OffEx
☐ Gold Access+ HMO® 0/35 OffEx
☐ Gold Access+ HMO® 500/35 OffEx
☐ Gold Access+ HMO® 1000/35 OffEx
☐ Gold Access+ HMO® 1500/35 OffEx
☐ Silver Access+ HMO® 2300/70 OffEx
☐ Silver Access+ HMO® 2750/70 OffEx
☐ Bronze Access+ HMO® 7000/70 OffEx

Local Access+ HMO plans – Local Access+ HMO Network

☐ Platinum Local Access+ HMO® 0/20 OffEx
☐ Platinum Local Access+ HMO® 0/25 OffEx
☐ Platinum Local Access+ HMO® 0/30 OffEx
☐ Gold Local Access+ HMO® 0/35 OffEx
☐ Gold Local Access+ HMO® 500/35 OffEx
☐ Gold Local Access+ HMO® 1000/35 OffEx
☐ Gold Local Access+ HMO® 1500/35 OffEx
☐ Silver Local Access+ HMO® 2300/70 OffEx
☐ Silver Local Access+ HMO® 2750/70 OffEx
☐ Bronze Local Access+ HMO® 7000/70 OffEx

Trio HMO plans – Trio ACO HMO Network

☐ Platinum Trio HMO 0/20 OffEx
☐ Platinum Trio HMO 0/25 OffEx
☐ Platinum Trio HMO 0/30 OffEx
☐ Gold Trio HMO 0/35 OffEx
☐ Gold Trio HMO 500/35 OffEx
☐ Gold Trio HMO 1000/35 OffEx
☐ Gold Trio HMO 1500/35 OffEx
☐ Silver Trio HMO 2300/70 OffEx
☐ Silver Trio HMO 2750/70 OffEx
☐ Bronze Trio HMO 7000/70 OffEx

Blue Shield of California Mirror Package Plans

☐ Blue Shield Platinum 90 PPO 0/15 PCP + Child Dental
☐ Blue Shield Gold 80 PPO 350/25 PCP + Child Dental
☐ Blue Shield Silver 70 PPO 2500/55 PCP + Child Dental
☐ Blue Shield Bronze 60 PPO 5800/60 PCP + Child Dental
☐ Blue Shield Silver 70 HDHP PPO 2300/30% PCP + Child Dental Alt
☐ Blue Shield Bronze 60 HDHP PPO 7500/0% PCP + Child Dental Alt
☐ Blue Shield Access+ Platinum 90 HMO® 0/20 PCP + Child Dental
☐ Blue Shield Access+ Gold 80 HMO® 250/35 PCP + Child Dental
☐ Blue Shield Access+ Silver 70 HMO® 2500/55 PCP + Child Dental
☐ Blue Shield Trio Platinum 90 HMO 0/20 PCP + Child Dental
☐ Blue Shield Trio Gold 80 HMO 250/35 PCP + Child Dental
☐ Blue Shield Trio Silver 70 HMO 2500/55 PCP + Child Dental
☐ Blue Shield Trio Bronze 60 HMO 7000/70 PCP + Child Dental Alt

* The Silver Full PPO 2100/65 OffEx and Silver Tandem PPO 2100/65 OffEx offer enhanced coverage for members diagnosed with diabetes, asthma, COPD, and CAD.

Subscriber name | Subscriber ID number | Group/employer name

Specialty benefit plans – Dental,* vision,* and life insurance* plan selection

* Only benefits your employer group offers are available for selection. Any benefits selected that are not offered by your employer group will be omitted from your enrollment.

Select one dental plan (Section SB1) and/or one vision plan (Section SB2) if offered by your employer.
Complete Section SB3 for Life/AD&D insurance if offered by your employer.

Section SB1 – Dental coverage

Dental HMO plans

☐ DHMO Basic ☐ DHMO Standard ☐ DHMO Plus ☐ DHMO Deluxe ☐ DHMO Voluntary‡

Dental PPO plans

☐ Bronze DPPO/$1000/MAC
☐ Bronze DPPO/$1000/MAC/Child Only Ortho
☐ Bronze DPPO/$1500/MAC
☐ Bronze DPPO/$1500/MAC/Child Only Ortho
☐ Silver DPPO/$1500/MAC
☐ Silver DPPO/$1500/MAC/Adult+Child Ortho
☐ Silver DPPO/$1500/U90
☐ Silver DPPO/$1500/U90/Adult+Child Ortho
☐ Gold DPPO/$1500/MAC
☐ Gold DPPO/$1500/MAC/Adult+Child Ortho
☐ Gold DPPO/$2000/MAC
☐ Gold DPPO/$2000/MAC/Adult+Child Ortho
☐ Gold DPPO/$1500/U90
☐ Gold DPPO/$1500/U90/Adult+Child Ortho
☐ Gold DPPO/$2000/U90
☐ Gold DPPO/$2000/U90/Adult+Child Ortho
☐ Platinum DPPO/$2500/U90
☐ Platinum DPPO/$2500/U90/Adult+Child Ortho
☐ Platinum DPPO/$3000/U90
☐ Platinum DPPO/$3000/U90/Adult+Child Ortho
☐ Platinum DPPO/$5000/U90
☐ Platinum DPPO/$5000/U90/Adult+Child Ortho
☐ Diamond DPPO/$3000/U95
☐ Diamond DPPO/$3000/U95/Adult+Child Ortho
☐ Diamond DPPO/$5000/U95
☐ Diamond DPPO/$5000/U95/Adult+Child Ortho

Dental PPO plans (only available for groups enrolled in these plans prior to 12/31/2021)

☐ Smile℠ Value 50/1500/No Ortho/MAC/NR
☐ Smile℠ 50/1500/No Ortho/MAC/NR
☐ Smile℠ Plus 50/1500/Ortho/MAC/NR
☐ Smile℠ Basic 75/1000/No Ortho/MAC/NR
☐ Smile℠ Basic 50/1000/No Ortho/MAC
☐ Smile℠ Plus 50/1500/No Ortho/MAC/WP
☐ Smile℠ Deluxe 50/1500/Ortho/MAC/NR
☐ Smile℠ Plus Gold 50/1500/Ortho/U80
☐ Smile℠ Plus Gold 50/2500/Ortho/U90/ADV
☐ Smile℠ Plus Gold 50/2500/No Ortho/U90/ADV
☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/U90

Voluntary Dental PPO plans**

☐ Bronze Voluntary DPPO/$1000/MAC
☐ Bronze Voluntary DPPO/$1500/MAC
☐ Bronze Voluntary DPPO/$1000/MAC/Child Only Ortho
☐ Bronze Voluntary DPPO/$1500/MAC/Child Only Ortho

Voluntary Dental PPO Plans (only available for groups enrolled in these plans prior to 12/31/2021)**

☐ Smile℠ Basic Voluntary 75/1000/No Ortho/MAC/NR
☐ Smile℠ Basic Voluntary 50/1000/No Ortho/MAC
☐ Smile℠ Basic Voluntary 50/1500/Ortho/U80
☐ Smile℠ Basic Voluntary 50/1000/No Ortho/U80 (No Wait)†

Dental In-Network Only (INO) plans† (only available for groups enrolled in these plans prior to 12/31/2018)

☐ Smile℠ INO Dental Plan 50/1500/Endo-Perio 80%/Ortho
☐ Smile℠ INO Dental Plan 50/1500/Endo-Perio 80%/No Ortho

Dental PPO plans (only available for groups enrolled in these plans prior to 12/31/2018)

☐ Smile℠ Deluxe Gold 50/1500/Ortho/U85
☐ Smile℠ Plus 50/1500/Ortho/MAC
☐ Smile℠ Value 50/1500/No Ortho/MAC
☐ Smile℠ Basic 75/1000/No Ortho/MAC
☐ Smile℠ Basic Voluntary 75/1000/No Ortho/MAC**

† Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

‡ This voluntary plan does not include Waiting Periods and submission of proof of any prior coverage is not required.

** The voluntary plans include a 12-month waiting period on major services and orthodontic services (ortho plan).

ADV stands for Advantage. ADV plans incentivize members to use in-network providers. NR stands for No Rollover.

All voluntary dental plans require a minimum of one (1) enrolling, eligible employee.

Subscriber name | Subscriber ID number | Group/employer name

Section SB2 – Vision coverage*

Ultimate Vision for Small Business (12-12-12)
- ❑ Ultimate Vision Plus 0/0/150/150
- ❑ Ultimate Vision 0/0/150
- ❑ Ultimate Vision Plus 10/25/150/150
- ❑ Ultimate Vision 10/25/150
- ❑ Ultimate Vision 0/0/120
- ❑ Ultimate Vision 10/25/120
- ❑ Ultimate Vision Voluntary 10/25/150[1]

Preferred Vision for Small Business (12-12-24)
- ❑ Preferred Vision Plus 0/0/150/150
- ❑ Preferred Vision 0/0/150
- ❑ Preferred Vision Plus 10/25/150/150
- ❑ Preferred Vision 10/25/150
- ❑ Preferred Vision 0/0/120
- ❑ Preferred Vision 10/25/120
- ❑ Preferred Vision Voluntary 10/25/120[1]

Basic Vision for Small Business (12-24-24)
- ❑ Basic Vision Plus 0/0/150/150
- ❑ Basic Vision 0/0/150
- ❑ Basic Vision Plus 10/25/150/150
- ❑ Basic Vision 10/25/150
- ❑ Basic Vision 0/0/120
- ❑ Basic Vision 10/25/120
- ❑ Basic Vision Voluntary 10/25/120[1]

❑ Other (please specify) _____

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

1 Voluntary vision plans require a minimum of one (1) enrolling, eligible employee.

Section SB3 – Life/AD&D insurance

Group term life insurance*

Employee information

Full-time employment date

Average hours worked per week

Earnings $ _____
(excluding overtime, bonuses, etc.)
❑ Hour ❑ Week
❑ Month ❑ Year

Rehire date

Class/occupation**

**Job classification is required when your employer offers life insurance that is based on job classifications.

Designation of beneficiary

Community property laws – If you are married or in a domestic partnership, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin) and name someone other than your spouse/domestic partner as beneficiary, it is possible that payment of benefits will be delayed or disputed unless your spouse/domestic partner also signs the beneficiary designation.

I agree to the stated beneficiary designation(s).

Spouse/domestic partner signature | Date

Spouse/domestic partner name (please print)

Primary beneficiary – Blue Shield Life will pay the life insurance benefits to the primary beneficiary/beneficiaries identified. An employee may designate more than one primary beneficiary. Please show percentages for each primary beneficiary in the "% of benefits" column to total 100% of benefits. If the percentage is not defined, the benefits will be distributed equally to those primary beneficiaries who survive the employee. To designate more than two primary beneficiaries, please provide on a separate sheet of paper, which is signed and dated by the employee, and attach to this form.

First name | MI | Last name | Social Security number | Relationship | Date of birth | % of benefits

Address | City | State | ZIP code

First name | MI | Last name | Social Security number | Relationship | Date of birth | % of benefits

Address | City | State | ZIP code

Subscriber name	Subscriber ID number	Group/employer name

Contingent beneficiary – Proceeds will be paid to a contingent beneficiary only if no designated primary beneficiary survives the insured.

First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits

Address	City	State	ZIP code

Employee and dependent benefit amounts

Please contact your benefits administrator for more information regarding your group life insurance coverage. Coverage granted to individuals listed in this enrollment form shall be subject to all provisions and limitations stated in the Blue Shield of California Life & Health Insurance Company group life insurance policy.

Employee Basic Life and AD&D Insurance amount: $ ___________ Amount of coverage requested for dependent(s): $ ___________

Number of eligible dependents: ___________ Basic Dependent Life Insurance: ☐ Yes ☐ No

* Underwritten by Blue Shield of California Life & Health Insurance Company.

If transferring to medical HMO and/or dental HMO plan(s), provide primary care physician/dental provider information below.*

Please complete this section for the subscriber and all of their dependents if they have a preferred provider. If no provider is received, a provider will be assigned for each member enrolled.

Last name	MI	First name	Sex ☐ Male ☐ Female	Date of birth
HMO provider name	**HMO provider number**	**Independent Practice Association/medical group**		**Current patient? ☐ Yes ☐ No**
Dental HMO provider name	**Dental HMO provider number**	**Dental group name**		**Current patient? ☐ Yes ☐ No**
Last name	**MI**	**First name**	**Sex ☐ Male ☐ Female**	**Date of birth**
HMO provider name	**HMO provider number**	**Independent Practice Association/medical group**		**Current patient? ☐ Yes ☐ No**
Dental HMO provider name	**Dental HMO provider number**	**Dental group name**		**Current patient? ☐ Yes ☐ No**
Last name	**MI**	**First name**	**Sex ☐ Male ☐ Female**	**Date of birth**
HMO provider name	**HMO provider number**	**Independent Practice Association/medical group**		**Current patient? ☐ Yes ☐ No**
Dental HMO provider name	**Dental HMO provider number**	**Dental group name**		**Current patient? ☐ Yes ☐ No**
Last name	**MI**	**First name**	**Sex ☐ Male ☐ Female**	**Date of birth**
HMO provider name	**HMO provider number**	**Independent Practice Association/medical group**		**Current patient? ☐ Yes ☐ No**
Dental HMO provider name	**Dental HMO provider number**	**Dental group name**		**Current patient? ☐ Yes ☐ No**

* Please note: If Blue Shield is unable to assign the primary care physician and/or dental HMO provider you requested, Blue Shield will designate a provider at random. HMO primary care physicians can be changed by visiting **blueshieldca.com** after enrollment.

Subscriber name	Subscriber ID number	Group/employer name

Acknowledgement and signature

I acknowledge and agree: All information I have provided on this form is accurate and complete to the best of my knowledge and belief. I understand that this form, along with any prior enrollment form, the *Evidence of Coverage* (EOC)*/Certificate of Insurance* and Health Service Agreement/Policy, and any endorsements and attachments thereto, collectively constitutes the entire agreement for coverage.

If you are enrolling yourself or dependents or making coverage changes during a Special Enrollment Period, you are attesting that you and/or the dependent enrolling has experienced one of the triggering events in the *Evidence of Coverage* (EOC) and that proof of this event is available upon request.

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of employee _____ **Date** _____

Print employee name _____

Keep a copy of this document for your files.

Blue Shield of California protects the privacy of your personal information, including your individually identifiable health information. We will not disclose your personal information without your authorization, except as permitted or required by law.
To obtain a copy of Blue Shield's Notice of Privacy Practices, call the customer service number on your Blue Shield member ID card or visit our website at **blueshieldca.com/privacy**.

PLEASE BE SURE TO RETURN ALL PAGES OF THIS FORM. Missing information or pages may delay processing.
Complete your Subscriber Change Request form at blueshieldca.com.