Small Business Subscriber Change Request
Blue Shield of California and
Blue Shield of California Life & Health Insurance Company

blue california

Effective October 1, 2018

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.

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 W0007504 Schuchert, Krieger, Truong, Spagnola & Klausner	Blue Shield Group ID (from ID card)	Requested effective date

Member information update

Address change

Please complete this section to update your address. Include both your full previous and full new address. HMO plans: If you have moved outside your primary care physician's service area, you will need to change 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	☐ Work ☐ Home	Old email address
New phone number	☐ Work ☐ Home	New email address

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.

Old name	New 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

Subscriber name	Subscriber ID number	Employer name Schuchert, Krieger, Truong, Spagnola & Klausner

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 is 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	**Reason for addition**	**Event date**
☐ Dependent child ☐ Spouse/domestic partner ☐ Dependent child: legal guardianship	☐ Newborn ☐ Domestic partnership ☐ Adoption ☐ Loss of coverage ☐ Court order ☐ Open enrollment ☐ Marriage	

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

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, is Refusal of Coverage form for those plans being declined attached? ☐ Yes ☐ No

Dependent 2

Relationship to employee	**Reason for addition**	**Event date**
☐ Dependent child ☐ Spouse/domestic partner ☐ Dependent child: legal guardianship	☐ Newborn ☐ Domestic partnership ☐ Adoption ☐ Loss of coverage ☐ Court order ☐ Open enrollment ☐ Marriage	

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

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, is Refusal of Coverage form for those plans being declined attached? ☐ Yes ☐ No

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	**Reason for cancellation**	**Event date**
☐ Dependent child ☐ Spouse/domestic partner	☐ Divorce ☐ Death ☐ Military deployment	☐ Other insurance coverage ☐ Termination of domestic partnership

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	Employer name
		Schuchert, Krieger, Truong, Spagnola & Klausner

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 0/10 OffEx
- ☐ Platinum Full PPO 250/15 OffEx
- ☐ Gold Full PPO 0/20 OffEx
- ☐ Gold Full PPO 450/30 OffEx
- ☐ Gold Full PPO 750/30 OffEx
- ☐ Gold Full PPO 1200/35 OffEx
- ☐ Silver Full PPO 1700/55 OffEx
- ☐ Silver Full PPO 2000/45 OffEx
- ☐ Bronze Full PPO 3750/65 OffEx
- ☐ Bronze Full PPO 5700/60 OffEx

HSA-compatible HDHP plans – Full PPO Network

- ☐ Silver Full PPO Savings 2000/20% OffEx
- ☐ Bronze Full PPO Savings 4300/40% OffEx
- ☐ Bronze Full PPO Savings 6550 OffEx

Tandem PPO plans – Tandem PPO Network

- ☐ Platinum Tandem PPO 0/10 OffEx
- ☐ Platinum Tandem PPO 250/15 OffEx
- ☐ Gold Tandem PPO 750/30 OffEx
- ☐ Silver Tandem PPO 1700/55 OffEx
- ☐ Silver Tandem PPO 2000/45 OffEx
- ☐ Bronze Tandem PPO 3750/65 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® 500/35 OffEx
- ☐ Gold Access+ HMO® 1700/35 OffEx
- ☐ Silver Access+ HMO® 1750/55 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® 500/35 OffEx
- ☐ Gold Local Access+ HMO® 1700/35 OffEx
- ☐ Silver Local Access+ HMO® 1750/55 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 500/35 OffEx
- ☐ Gold Trio HMO 1700/35 OffEx
- ☐ Silver Trio HMO 1750/55 OffEx

Blue Shield of California Mirror Package Plans

- ☐ Blue Shield Platinum 90 HMO 0/15 Trio + Child Dental
- ☐ Blue Shield Platinum 90 PPO 0/15 + Child Dental
- ☐ Blue Shield Gold 80 HMO 0/25 Trio + Child Dental
- ☐ Blue Shield Gold 80 PPO 0/25 + Child Dental
- ☐ Blue Shield Silver 70 HMO 2000/45 Trio + Child Dental
- ☐ Blue Shield Silver 70 PPO 2000/45 + Child Dental
- ☐ Blue Shield Bronze 60 PPO 6300/75 + Child Dental

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

Please complete the attached Specialty Benefits Employee Benefit Selection form to indicate changes to specialty benefit coverage.

Section 2.1 – Dental benefits

Dental HMO plans

☐ DHMO Basic	☐ DHMO Plus	☐ DHMO Deluxe	☐ DHMO Voluntary

Dental PPO plans

- ☐ Ultimate Dental PPO for Small Business 50/2000
- ☐ Ultimate Dental Plus PPO for Small Business 50/2000
- ☐ Smile℠ Deluxe 2000 50/2000/No Ortho/MAC
- ☐ Smile℠ Deluxe Plus 2000 50/2000/Ortho/MAC
- ☐ Smile℠ Deluxe 50/1500/Ortho/MAC
- ☐ Smile℠ Deluxe Gold 50/1500/Ortho/U85
- ☐ Smile℠ 50/1500/No Ortho/MAC
- ☐ Smile℠ Plus 50/1500/Ortho/MAC
- ☐ Smile℠ Value 50/1500/No Ortho/MAC
- ☐ Smile℠ Plus Gold 50/1500/Ortho/U85
- ☐ Smile℠ Basic 75/1000/No Ortho/MAC
- ☐ Smile℠ Voluntary 75/1000/No Ortho/MAC

Dental In-Network Only (INO) Plans*

- ☐ Smile℠ INO Dental Plan 50/1500/Endo-Perio 80%/Ortho
- ☐ Smile℠ INO Dental Plan 50/1500/Endo-Perio 80%/No Ortho
- ☐ Smile℠ INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/Ortho[1]
- ☐ Smile℠ INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/No Ortho[1]
- ☐ Smile℠ INO Dental Plan 50/2500/Endo-Perio 80%/Ortho
- ☐ Smile℠ INO Dental Plan 50/2500/Endo-Perio 80%/No Ortho
- ☐ Smile℠ INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/Ortho[1]
- ☐ Smile℠ INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/No Ortho[1]
- ☐ Other (please specify)

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

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

Subscriber name	Subscriber ID number	Employer name

Section SB2 – Vision coverage

Vision coverage

Ultimate Vision for Small Business (12-12-12)	Preferred Vision for Small Business (12-12-24)	Enhanced Vision for Small Business (12-24-24)
☐ Ultimate Vision Plus 0/0/150/120	☐ Preferred Vision Plus 0/0/150/120	☐ Enhanced Vision Plus 0/0/150/120
☐ Ultimate Vision 0/0/150	☐ Preferred Vision 0/0/150	☐ Enhanced Vision 0/0/150
☐ Ultimate Vision Plus 15/25/150/120	☐ Preferred Vision Plus 15/25/150/120	☐ Enhanced Vision Plus 15/25/150/120
☐ Ultimate Vision 15/25/150	☐ Preferred Vision 15/25/150	☐ Enhanced Vision 15/25/150
☐ Ultimate Vision 0/0/120	☐ Preferred Vision 0/0/120	☐ Enhanced Vision 0/0/120
☐ Ultimate Vision 15/25/120	☐ Preferred Vision 15/25/120	☐ Enhanced Vision 15/25/120
☐ Ultimate Vision Voluntary 15/25/150[1]	☐ Preferred Vision Voluntary 15/25/120[1]	☐ Enhanced Vision Voluntary 15/25/120[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	Rehire date	Class/occupation	Earnings $ _____ (excluding overtime, bonuses, etc.) ☐ Hour ☐ Week ☐ Month ☐ Year

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 no 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	

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	

Subscriber name	Subscriber ID number	Employer name
		Schuchert, Krieger, Truong, Spagnola & Klausner

Information on 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.

Dependent information

Number of eligible dependents: ____________	Basic Dependent Life Insurance: ☐ Yes ☐ No
Employee Basic Life and AD&D Insurance amount: $ ____________	Amount of coverage requested for dependent(s): $ ____________ (Minimum amount of coverage is $1,000; maximum is $5,000)

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

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

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			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			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			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			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.

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/Certificate of Insurance* and Health Service Agreement/Policy, and any endorsements and attachments thereto, collectively constitutes the entire agreement for coverage.

Signature of employee ________________________________ **Date** ____________

Print employee name ________________________________

If faxing this form, keep 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/bsca/documents/about-blue-shield/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.

Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html.**