



Request for Change in Membership - Group

WITH BLUE CROSS AND BLUE SHIELD OF OKLAHOMA • P.O. BOX 3283, TULSA, OKLAHOMA 74102-3283
A Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

CHECK THE BOX THAT APPLIES:
 Group Health only
 Group Dental only
 Group Health and Group Dental

PLEASE PRINT IN INK OR TYPE CHECK APPROPRIATE BOX(ES):
 NAME OR ADDRESS CHANGE COMPLETE ITEMS 1 THROUGH 3, & 7
 TERMINATION COMPLETE ITEMS 1 THROUGH 4, & 7
 ADDING/DROPPING DEPENDENTS COMPLETE ITEMS 1 THROUGH 3 & 5 THROUGH 7

1 MEMBER S NAME (LAST, FIRST, MIDDLE) **NAME CHANGE** NEW NAME (LAST, FIRST) RESIDENCE TELEPHONE

2 ADDRESS (STREET OR BOX NO.) (CITY) (STATE) (ZIP) COUNTY NEW ADDRESS YES NO

3 SUBSCRIBER ID NO. PRESENT GROUP NO. I AM EMPLOYED BY (NAME OF COMPANY, CITY, STATE) BUSINESS TELEPHONE

4 TERMINATION I REQUEST TERMINATION OF COVERAGE AS I AM NO LONGER EMPLOYED AS OF Mo. Day Yr. I REQUEST TERMINATION OF COVERAGE WITHOUT LEAVING EMPLOYMENT AS OF Mo. Day Yr.

5 ADDING/DROPPING DEPENDENTS

CHANGE MY MEMBERSHIP TO:
 EMPLOYEE ONLY **EMPLOYEE AND SPOUSE** **EMPLOYEE AND UNMARRIED CHILDREN** **EMPLOYEE, SPOUSE AND UNMARRIED CHILDREN**

PLEASE COMPLETE, READ AND SIGN ITEMS 1 THROUGH 3, AND 5 THROUGH 7

IF DEPENDENT ADDED OR DROPPED, GIVE REASON AND DATE OF:
 DEATH DIVORCE BIRTH MARRIAGE ADOPTION LOSS OF OTHER COVERAGE OTHER (Need adoption papers) (Provide certificate of coverage) (Give reason) MO. DAY YR.

FULL NAME OF SPOUSE (FIRST, MIDDLE, LAST) DATE OF BIRTH Mo. Day Yr. SPOUSE S SOCIAL SECURITY NO. ADD DROP

IF DEPENDENT OR SPOUSE IS NOW BCBS MEMBER: GROUP NO. AGREEMENT NO. (SUBSCRIBER ID NO.) SPOUSE S PLACE OF EMPLOYMENT DATE EMPLOYED

DEPENDENT S FULL NAME (LAST, FIRST, MIDDLE) RELATIONSHIP TO EMPLOYEE SON/STEP-SON DAUGHTER/STEP-DAUGHTER OTHER (DESCRIBE) DATE OF BIRTH ADD DROP

SOCIAL SECURITY NUMBER DEPENDENT S PRIMARY CARE PHYSICIAN (PHYSICIAN S FULL NAME) (IF APPLICABLE) IS THIS YOUR DEPENDENT S CURRENT PHYSICIAN YES NO PCP NUMBER FROM PROVIDER DIRECTORY **PCP-**

IS THIS DEPENDENT A NATURAL CHILD, STEP-CHILD, OR ADOPTED CHILD? IF NO, ATTACH COPY OF SIGNED COURT DECREE. YES NO
IS THIS DEPENDENT MARRIED? YES NO
ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? YES NO
IF DEPENDENT IS OVER AGE 19, IS THE DEPENDENT A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY? IF YES, COMPLETE THE FOLLOWING: YES NO

NAME OF COLLEGE: CITY/STATE HOURS ENROLLED

DEPENDENT S FULL NAME (LAST, FIRST, MIDDLE) RELATIONSHIP TO EMPLOYEE SON/STEP-SON DAUGHTER/STEP-DAUGHTER OTHER (DESCRIBE) DATE OF BIRTH ADD DROP

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DEPENDENT S FULL NAME (LAST, FIRST, MIDDLE) RELATIONSHIP TO EMPLOYEE SON/STEP-SON DAUGHTER/STEP-DAUGHTER OTHER (DESCRIBE) DATE OF BIRTH ADD DROP

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ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? YES NO
IF DEPENDENT IS OVER AGE 19, IS THE DEPENDENT A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY? IF YES, COMPLETE THE FOLLOWING: YES NO

NAME OF COLLEGE: CITY/STATE HOURS ENROLLED

6 DOES ANYONE LISTED ON THIS APPLICATION HAVE HEALTH INSURANCE, MEDICARE OR MEDICAID, OR HAS ANYONE LOST COVERAGE DURING THE LAST 2 MONTHS? YES NO IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION: INSURANCE COMPANY NAME

INSURED S NAME MEMBER ID/SUBSCRIBER NO./CASE NO. GROUP NO./POLICY NO. PERSONS COVERED APPLICANT SPOUSE DEPENDENTS LISTED ON APPLICATION OTHER

HAS COVERAGE TERMINATED? YES NO IF NO, WILL YOUR CURRENT COVERAGE BE TERMINATED IF THIS COVERAGE IS APPROVED? YES, CURRENT COVERAGE WILL BE TERMINATED NO, I WILL KEEP BOTH COVERAGES NOTE: IF MORE THAN (1) ONE INSURANCE POLICY, PLEASE PROVIDE THE INFORMATION ON ITEM 6 FOR ADDITIONAL INSURANCE CARRIERS ON A SEPARATE PIECE OF PAPER AND ATTACH IT TO THIS APPLICATION.

OFFICE USE ONLY GROUP NO. F/C AGREEMENT NO. F/C CODE QWA CODE WVA CODE EXP. DATE GROUP ID DIV CODE CROSS-REF AGREEMENT NO. COB CODE CO CODE INVOICE NO. MS CODE MSC DATE CHAR. CODE DATE SUB BASIC CHAR. DEP. BASIC CHAR. SUB DENTAL CHAR. DEP. DENTAL CHAR.

SPLIT MEMBERSHIP CHANGES: Please do not terminate the dependents under this membership _____, until the new membership has been established under ID number _____

APPROVED BY DATE PROCESSED APPROVAL DATE (EFFECTIVE DATE) DROP EFFECTIVE DATE

