Group Member Change Form

for Alliance Medical Coverage, plus Optional Dental and Life/AD&D Disability Products

Subscriber note: Be sure to keep a copy for your records. Use a second Change Authorization Form if necessary.

Please Print — ***Be Sure to See Reverse Side***

Subscriber's name: *last* *first* *middle* | Current Group no. | Current Identification no.

Subscriber's address: *street* *city* *state* *Zip code*
Complete only if a new address

Are you: ☐ retired / ☐ full-time active employee

Complete only the sections that apply to the change(s) you wish to make. Note: All the options listed in Sections 1, 2 and 3 may not be available to your group. Ask your Group Administrator which options are available to you.

1. Change Coverage Type to: ☐ Subscriber only ☐ Subscriber and spouse ☐ Subscriber and child(ren) ☐ Subscriber, spouse and child(ren)

2. Change Coverage to *(please check appropriate boxes):*

☐ Medical only — For: ☐ self ☐ spouse ☐ child(ren) ☐ family
☐ Dental only — For: ☐ self ☐ spouse ☐ child(ren) ☐ family
☐ Medical and Dental — For: ☐ self ☐ spouse ☐ child(ren) ☐ family
☐ Retirement Program — For: ☐ self ☐ spouse ☐ child(ren) ☐ family

For OptionBlue Groups
Change medical option to *(check one):*
☐ Base PPO Plan ☐ Enriched PPO Plan
☐ Premium PPO Plan *(only for groups of 51+)*

For Dental Option* Groups *(if applicable)*
**Available only for groups of 51+.*
Not available with DentaBlue Select.
Change dental option to *(check one):*
☐ Base Plan ☐ Enriched Plan

Note: *This change can be made only at the time of your group's annual renewal.*

For members enrolled in an HSA-Compatible Medical Plan:
(complete if appropriate)

☐ I established, or will establish, a Health Savings account on (date): _____/_____/_____.

☐ I closed, or will close, my Health Savings account on (date): _____/_____/_____.

3. Add/Delete/Change Information

Medical/Dental Coverages: *(See your benefit materials for information about adding dependents.)*

Check One: Add / Delete / Change	First Name	M.I.	Last, *if different*	Sex M/F	Relationship to Subscriber	Date of Birth mo	day	yr
☐ ☐ ☐								
☐ ☐ ☐								
☐ ☐ ☐								

Other Coverage: ***Important – Failure to complete the following questions may result in claims delays.***

Does anyone being added above have other health insurance (other than Medicare) that will remain in effect after this coverage begins?

☐ Yes ☐ No If **yes,** give name(s):______________________________ ______________________________ ______________________________

Insurance company name, address and phone #:

Check one: ☐ Individually purchased
☐ Purchased through a group

If through a group, give group name:

Check one or both: ☐ Medical ☐ Dental

Check one: ☐ Individual ☐ Family

Medicare Information: If you or any dependents are enrolled in Medicare, please give the following Medicare information:

Name:______________________________________ Medicare claim no. *(include letter):* ________________________

Effective date(s) *(mo/day/yr)* : Part A ____/____/____ Part B ____/____/____ Part D* ____/____/____

*Name of Part D carrier:____________________________________

Check reason eligible: ☐ Age ☐ Disability ☐ End-stage renal disease

Life/AD&D and Disability Coverages:

Add: ☐ Basic Life/AD&D ☐ Dependent Life† ☐ STD ☐ LTD
Delete: ☐ Basic Life/AD&D ☐ Dependent Life† ☐ STD ☐ LTD

†Not available without Basic Life/AD&D. Dependent Life age limits differ from medical coverage age limits.

Change class no. & job description to: | Change base salary to: $
Effective Date: | Effective Date:

Change Beneficiary(ies) to: | Relationship

4. Change Name: From: *Last* *first* *middle* To: *Last* *first* *middle*

5. Reason for change(s) *(check all that apply):*

Date of the event you checked: ______________________

☐ Subscriber's marriage
☐ Add newborn child to membership
☐ Adoption/legal custody of child *(attach required legal documents)*
☐ Other *(explain):*
☐ Cover newborn child for first 31 days only
☐ Student status verification *(attach documentation)*
☐ Subscriber's divorce
☐ Enrollment in Medicare
☐ Child reached dependent age limit
☐ Disenrollment from Medicare
☐ Child's marriage
☐ Retirement
☐ Death

6. Cancel Coverage
Last day of coverage *(date):*

Reason for cancellation: ☐ Subscriber's request ☐ Left employment
Other reason:

Signature: No action requested can be taken without your signature. *Before signing,* please read the ***Statement of Understanding*** on the reverse side.

I agree to the *Statement of Understanding* on the reverse side, with the same date as this page.

X ____________________________________ *(Subscriber's signature)*

X ____________________________________ *(Subscriber's printed name)*

X ______________ *(Date)*

(over)

The Companies are Healthy Alliance® Life Insurance Company (HALIC), its parent, RightCHOICE® Managed Care, Inc. (RIT), and certain affiliates. Blue Cross Blue Shield of Missouri is the name RIT uses to do business in most of Missouri. RIT and certain affiliates administer benefits underwritten by HALIC. RIT and HALIC are independent licensees of the Blue Cross and Blue Shield Association.

For complete information about your program and about making membership changes, please refer to your benefit materials.

Statement of Understanding

Please read carefully before signing.

Subscriber (the person completing and signing this form) **understands and agrees to all the items listed below**, **on behalf of himself/herself and as the authorized representative of his/her spouse and other covered dependents.**

I understand that this Change Form is for the purpose of enrolling in health, dental and other non-health products, such as life and disability products. The information on this form, except for health history and health status, will be shared with the non-health affiliates of the Companies for the purpose of maintaining enrollment and billing services.

I hereby authorize the Companies to take the actions requested on this form.

I represent that the information provided on this form is true and correct and that all persons listed are eligible.

Dental Coverage: I understand that if I am adding dental coverage, waiting periods may apply for certain services as specified in my benefit materials.

Life/AD&D and Disability Products: I understand that if I want to add Life/AD&D and/or disability coverage, I will need to complete a health history form, and satisfy medical underwriting requirements. I also understand that waiting periods may apply for long-term disability and/or short-term disability coverage, as specified in my group's Master Policy underwritten by Healthy Alliance Life Insurance Company.

Completeness and Accuracy: I understand that the Companies rely upon the information provided on this form, plus any information obtained from my family physician(s), in issuing my coverage. If I omit any information or provide any false or incomplete information that is considered fraud or material misrepresentation, this can result in the cancellation of my coverage based on the terms of my Certificate. I agree to repay promptly any benefit payment to which I or my dependents were not entitled.