

Change Form

for First Choice coverage



For office use only

Sys. Number	Rep. Number	Date
Business Name		

Section 1 – Applicant Information

First Name _____ MI _____ Gender Male Female Date of Birth _____

Last Name _____ Suffix _____ Social Security Number _____

Residential Address _____ Home Phone Number _____ Cell Phone Number _____

City _____ E-mail Address _____

State _____ ZIP Code _____ +4 _____ County _____ Employed by _____

Mailing Address (if different from residential address) _____ Work Phone Number _____ Work Fax Number _____

City _____ Group Number _____

State _____ ZIP Code _____ +4 _____ Member ID Number _____

Section 2 – Change of Name or Address

Change name to:

First Name _____ MI _____

Last Name _____ Suffix _____

Change address to:

Street Address or P.O. Box _____

City _____

State _____ ZIP Code _____ +4 _____

Section 3 – Add Family Members to Coverage

Please add family members to my existing policy. *Add Health Profile for all individuals being added, if applicable.*

Give reason for change: Birth/adoption Marriage Divorce Involuntary loss of coverage Other

Date of Occurrence _____

Relationship to applicant: Spouse Child Stepchild Legal Guardianship Legal Custody

First Name _____ MI _____ Gender Male Female Date of Birth _____

Last Name _____ Suffix _____ Social Security Number _____ Date of Adoption _____

Relationship to applicant: Spouse Child Stepchild Legal Guardianship Legal Custody

First Name _____ MI _____ Gender Male Female Date of Birth _____

Last Name _____ Suffix _____ Social Security Number _____ Date of Adoption _____

Relationship to applicant: Spouse Child Stepchild Legal Guardianship Legal Custody

First Name _____ MI _____ Gender Male Female Date of Birth _____

Last Name _____ Suffix _____ Social Security Number _____ Date of Adoption _____

Section 4 – Combine Blue Cross Policies

First Name _____ MI _____ First Name _____ MI _____
Last Name _____ Suffix _____ Last Name _____ Suffix _____
Existing BCBSKS Identification Number _____ Existing BCBSKS Identification Number _____

Section 5 – Remove Family Members from Coverage

Check one:

Change to myself only Change to myself/my spouse Change to myself/my child(ren)

Retain family and terminate coverage for: _____

If changing to sponsored coverage, see Section 6.

Give reason for change:

Divorce Child reaching age limit Death Other (give reason): _____

Date of Occurrence

Relationship to applicant: Spouse Child Stepchild Legal Guardianship Legal Custody

First Name _____ MI _____ Gender Male Female _____
Date of Birth

Last Name _____ Suffix _____ Social Security Number _____

Relationship to applicant: Spouse Child Stepchild Legal Guardianship Legal Custody

First Name _____ MI _____ Gender Male Female _____
Date of Birth

Last Name _____ Suffix _____ Social Security Number _____

Section 6 – Sponsored Coverage

Issue due to:

Divorce

Date of Occurrence

Child reaching age limit

First Name _____ MI _____

Last Name _____ Suffix _____

Issue:

Single Contract

Family Contract

(add Health Profile form for spouse and dependents)

Street Address _____

City _____

State _____ ZIP Code _____ +4 _____ Social Security Number _____

Section 7 – Other Changes and Comments

I represent that all statements made herein are complete and true to the best of my knowledge. I understand that if I fail to provide any material information or if I intentionally misrepresent any material fact, such omission or intentional misrepresentation may result in the re-rating, termination or rescission of my health care coverage and/or criminal prosecution.

Your signature required

Applicant (Signature of parent/guardian if other than applicant)

Date Signed