



BlueCross BlueShield of Minnesota
An Independent licensee of the Blue Cross and Blue Shield Association

Casefolder: _____ INDIVIDUAL MSA BLUE CHANGE FORM

If you need assistance, please call the customer service number located on the back of your card.

Instructions: Please check the appropriate box and answer all questions relating to the change you'd like to make. For prompt consideration, all change requests must include the contract holder's signature on the reverse side of this form.

Note: This form cannot be used to change to Aware Care, except for dependents listed under Section J. You must complete the Aware Care Change Form.

Contract holder name _____ Contract holder Group number _____
Contract holder ID number _____ Your agent's name _____

**IMPORTANT NOTE: This form is for enrollment into the health plan only.
Contact your agent for information about applying for a medical savings account (MSA).**

A. Cancellation and termination of coverage

I understand my coverage will cancel effective at 12:01 a.m. on the date designated below, provided that this form is received on or before the requested date.

Month Day Year _____ (requested termination date)

Reason: Death Medicare Other Insurance Military Other _____

Checking this box will cancel the entire contract. Please use Section G to delete the contract holder.

B. Address change

Home/mailling address Work phone number _____ Home phone number _____

Change my address to _____

C. Name change

From _____ to _____

Reason (required) _____ Event date _____

D. The effective date of this change will be the first of the month. Please indicate the "MONTH" you would like this change to occur: _____. Coverage must be paid to the requested date. If you do not indicate a month the effective date will be assigned according to the receipt date and billing cycle. ***For Monthly Billing Subscribers:** The effective date of this change will be the 1st or 15th of the month according to the billing cycle.

Change my coverage to (select only one):

Options Blue for individuals 80: Low Deductible Middle Deductible High Deductible
Options Blue for individuals 100: Low Deductible Middle Deductible High Deductible

*You must select one:

Preventive care 100% up to a \$300 maximum per calendar year Preventive Care (subject to deductible)

Verify with your agent the options available without a health history and the current deductible amounts available. Your agent will also be able to provide you with the rates for these products. The deductible and out-of-pocket maximum benefits are subject to annual adjustments. These adjustments are based on the Consumer Price Index (CPI) published by the Federal Department of Labor.

*NOTE: There is an additional charge for preventive coverage at 100%

E. Request for discount for not using tobacco (including smokeless tobacco)

I have not used tobacco during the 24 months immediately preceding the signature date on this change form.

Date last used tobacco Month Day Year _____

My spouse* has not used tobacco during the 24 months immediately preceding the signature date on this change form.

Date last used tobacco Month Day Year _____

*Your spouse's signature is required to expedite this change.

F. Behavioral Health Substance Abuse

Please remove substance abuse coverage from my current contract. I understand the deletion of this benefit applies to all persons covered by this contract.

Please review my application to add substance abuse coverage to my current contract. I understand there is an additional charge for this coverage and this is not guaranteed issue. Attached is a fully completed health history application (F7637). BCBSM will notify you in writing of the final decision concerning the request to add substance abuse coverage. Your current coverage will not be cancelled if the underwriting department determines you are ineligible to add this benefit to your contract.

G. Deletion of contract holder (please check the reason and provide the event date):

Reason: Death/date of death Medicare/date of enrollment Other _____

NOTE: Complete section I if your spouse or dependents are to retain coverage.

Date of event Month Day Year _____

H. Deletion of dependent(s)

Delete coverage for the following dependent(s) _____

Reason (required) _____ Date of event

Full name of dependent(s)		
Month	Day	Year

If you are deleting coverage for your spouse and/or dependent(s) due to divorce, they may have the right to retain coverage in their own name(s). Both subscriber and former spouse addresses are required. Please provide the following information.

Dependent's Social Security number: _____ Dependent's address _____

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I. Spouse, divorced spouse and/or dependent(s) to retain coverage (Your dependent child must complete Section J to retain coverage.)

Request coverage in dependent's name _____
 Dependent's Social Security number -- _____ *If divorced, we need both party's addresses

Unless especially requested or you are notified of a change, your coverage will continue at the same level of benefits. The coverage will be identified under the spouse's or dependent's name and Social Security number. Any riders or exclusions for you or your dependents on your current contract will carry over to the coverage under your spouse's or dependent's name.

J. Request for 36 month Continuation of Coverage or Replacement of Coverage (You may only select one option.)

Dependent's Name: _____

A dependent who is no longer eligible due to reaching age 25 or married prior to age 25 may elect:

- I am requesting a 36 month continuation of coverage on this contract. (Contract holder's signature required.)
- I am requesting a replacement contract in my own name. My Social Security Number _____
- I am requesting to change to an individual Blue Cross and Blue Shield Aware Care Contract. If my current deductible is not available, my election must be higher than the Options Blue Contract deductible.
 - \$2,000 \$3,000 \$5,000 - 80%* benefit percentage \$5,000 - 100% benefit percentage \$10,000

***Out-of-pocket expense explanation:** After you satisfy the \$5,000 deductible each year, this option pays benefits at 80% for the first \$10,000 of eligible expenses, and then 100% until the end of the year. If you choose the \$5,000 (80%) option, you will be responsible for a larger share of your expenses every year. If you choose to increase your coverage to the 100% option at a future date, you will need to complete a health history. (Health history application is subject to Underwriting Department approval.)

Tobacco Designation (Available only to those choosing the replacement option)

- I have not used tobacco during the 24 months immediately preceding the signature date on this form.
- I have used tobacco during the 24 months immediately preceding the signature date on this form.
Last used tobacco ___/___/___ **Complete section B if address is different.**

K. Please combine our contracts under my name spouse's name

Our identification numbers are: -- and --

L. Dependent addition(s)

Request addition of _____ Date of Birth

Month	Day	Year

Dependent is: Newborn Stepchild Grandchild Court ordered addition (provide legal document)
 Adopted child: (provide copy of legal document advising date of placement)
 Other _____

Requests to include dependents may require an application or health history form to be completed.

This form may be used only to decrease your benefits, to make the changes listed above, or to terminate coverage. Your coverage must be paid to the requested date, and this form **must be received in our office prior** to the requested date for this change to be made.

I/We understand and agree that this request will not alter any other limitations, conditions, provisions, or exclusions that were part of the contract or application prior to this change.

Contract holder's signature **X** _____ Date

Month	Day	Year

Spouse or dependent's signature **X** _____ Date

Month	Day	Year

Work telephone number (_____) _____ Area Code Cellular phone number (_____) _____ Area Code

Home telephone number (_____) _____ Area Code