

CHANGING A MEMBER'S STATUS

Changing Status

The *Enrollment and Change Form* is used for most membership status changes. Some status changes, such as a dependent child becoming an eligible full-time student, require a different form. The numbers in parentheses below direct you to an example of how to complete the appropriate form when changing a member's status.

You can make the following changes at any time:

- Name (5-2)
- Address (5-2)
- For managed care plans: you may change your primary care physician anytime after enrollment (5-7)

Other changes are effective on the date of a member's qualifying event. These events include:

- Marriage of the subscriber (5-2)
- Divorce of the subscriber (5-2)
- Birth, legal guardianship, or adoption of a dependent child (5-2)
- A dependent child becomes an eligible full-time student (3-7)
- A dependent child reaches the maximum age limit for coverage under a family contract (5-6)
- A member reaches age 65 (7-12)
- Death of a member (5-6)

All other changes are effective only on your group's contract renewal date.

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The following example shows how to change an address. You may also use this example for some of the other member changes listed on the previous page.

BlueCross BlueShield of Massachusetts		Please Read The Instructions Before Filing Out This Form.		Enrollment and Change Form	
An Independent Member of the Blue Cross and Blue Shield Association				Please mail to: BCBS, P.O. Box 9145, North Quincy, MA 02171-9145	
1. To Be Filled Out by Your Employer					
Company Name Royce Farms		Current Medical Group 0123456		Medical Group Transferring To	
Current Policy ID Number, if any 012345678		Renewal Effective Date 03 01 2000	Date of Hire	Initial Eligibility Date	Current Dental Group
Type of Transaction <input checked="" type="checkbox"/> Add <input checked="" type="checkbox"/> Change <input type="checkbox"/> Cancel		Remarks (i.e., qualifying event for a new add, change to family, or further instructions) Please update new address			
2. Tell Us About Yourself (Member 1)					
What product are you seeking? <input checked="" type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> Long Term Care <input type="checkbox"/> Other		Kind of Membership (Medical) <input checked="" type="checkbox"/> Individual <input type="checkbox"/> Family		Kind of Membership (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> Family	
Your First Name Heather		M: Last Name A. Allen		Sex F	Age of Member 23
Street Address, P.O. Box No. 42 Beacon Street		Appt. No. 3	City/Town Cambridge	State MA	Zip Code 02140
Social Security No. 012345678		Home Telephone No. (include area code) (617)555-1212	Other Insurance? Y/N	Other Insurance Company Name	
Name of PCP [Blank]		City/State		PCP ID Number	Is this your current PCP? Yes, if yes <input type="checkbox"/>
Part A Effective Date		Part B Effective Date		Medicare No. <input type="checkbox"/> 65+ <input type="checkbox"/> disabled <input type="checkbox"/> ESRD	Actively Working Y/N
* If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.					
3. Tell Us About Your Spouse (Member 2)					
Spouse's First Name		M: Spouse's Last Name		Sex	Date of Birth
Social Security No.		Home Telephone No. (include area code)		Other Insurance Company Name	
Name of PCP		City/State		PCP ID Number	Is this your current PCP? Yes, if yes <input type="checkbox"/>
Part A Effective Date		Part B Effective Date		Medicare No. <input type="checkbox"/> 65+ <input type="checkbox"/> disabled <input type="checkbox"/> ESRD	Actively Working Y/N
4. Tell Us About Your Dependents (Members 3, 4, and 5)					
Child's First Name		M: Child's Last Name		Sex	Full-time student? Age 19 or over Y/N
Date of Birth		Social Security No.		PCP ID Number	Name of PCP
Child's First Name		M: Child's Last Name		Sex	Full-time student? Age 19 or over Y/N
Date of Birth		Social Security No.		PCP ID Number	Name of PCP
Child's First Name		M: Child's Last Name		Sex	Full-time student? Age 19 or over Y/N
Date of Birth		Social Security No.		PCP ID Number	Name of PCP
The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I authorize Blue Cross and Blue Shield to obtain medical records or information from the Social Security Administration, Medicare contractors, other health care programs, insurers or any government agency to verify eligibility, claims payment information or properly coordinate benefits.					
Employer's Signature Heather A. Allen		Date 3/1/00	Employee Signature A. Spicer		Date 3/1/00

Remember:

- When changing a member's name or address, write "Name change" or "Address change" in the Remarks section.
- When changing status due to divorce, change membership to individual coverage if dependents are no longer covered and write "Change membership to individual due to divorce." in the Remarks section.
- When changing status due to birth, legal guardianship, or adoption, make sure to add all appropriate dependent information in the dependent sections and describe the type of dependent change in the Remarks section.

Important note: Please review forms carefully before submitting. Be sure to describe the requested transaction in the Remarks section.

Call Your Account Service Representative for More Information on This Subject

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Transferring Coverage

An employee's membership can be transferred only if the following conditions exist:

- There is a qualifying event
- During your group's open enrollment period, a subscriber transfers from one plan which is administered by Blue Cross Blue Shield to another plan administered by Blue Cross Blue Shield.

The following example shows how to do a subscriber transfer from one group to another during open enrollment.

Blue Cross BlueShield of Massachusetts		Please Read The Instructions Before Filling Out This Form.		Enrollment and Change Form	
An Independent Licensee of the Blue Cross and Blue Shield Association				Please mail to: BCBS, P.O. Box 9148, North Quincy, MA 02171-9148	
1. To Be Filled Out by Your Employer					
Employer Name PAINTER COMPANY		Current Medical Group 0123450		Medical Group Transferring To 0123450	
Current BCBS ID Number, if any 012345678		Effective Date 02/01/2000		Current Group Code 0123450	
Type of Transaction Add <input type="checkbox"/> Change <input checked="" type="checkbox"/> Cancel <input type="checkbox"/>		Remarks (i.e., qualifying event for a new add, change to family, or further instructions) OPEN ENROLLMENT - TRANSFER FROM 0123450 TO 0123450			
2. Tell Us About Yourself (Member 1)					
What product are you seeking? Individual <input checked="" type="checkbox"/> Family <input type="checkbox"/>		Kind of Membership (Medical) Individual <input checked="" type="checkbox"/> Family <input type="checkbox"/>		Kind of Membership (Dental) Individual <input type="checkbox"/> Family <input type="checkbox"/>	
Your First Name SHIRLEY		M.I. Last Name SNEED		Sex F	
Date of Birth 06/01/1945		Home Address / P.O. Box No. 5 JOHNSON ROAD BOSTON MA 02110		City/State	
Social Security No. 012345678		Home Telephone No. (include area code) (617) 995-3971		Other Insurance Company Name DR SMITH SALEM, MA	
Name of PCP DR SMITH		City/State SALEM, MA		PCP ID Number 113212595	
Part A Effective Date 01/01/00		Part B Effective Date 01/01/00		Medicare No. <input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> CSRD <input type="checkbox"/>	
Actively Working Y/N <input checked="" type="checkbox"/>		Retired Y/N <input type="checkbox"/>			
* If you have not indicated Yes or No regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.					
3. Tell Us About Your Spouse (Member 2)					
Spouse's First Name		M.I. Spouse's Last Name		Sex	
Date of Birth		Home Telephone No. (include area code)		Other Insurance Y/N	
Social Security No.		City/State		Other Insurance Company Name	
Name of PCP		City/State		PCP ID Number	
Part A Effective Date		Part B Effective Date		Medicare No.	
Actively Working Y/N		Retired Y/N			
4. Tell Us About Your Dependents (Members 3, 4, and 5)					
Child's First Name		M.I. Child's Last Name		Sex	
Date of Birth		Social Security No.		PCP ID Number	
Name of PCP		City/State			
Child's First Name		M.I. Child's Last Name		Sex	
Date of Birth		Social Security No.		PCP ID Number	
Name of PCP		City/State			
Child's First Name		M.I. Child's Last Name		Sex	
Date of Birth		Social Security No.		PCP ID Number	
Name of PCP		City/State			
The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I authorize Blue Cross and Blue Shield to obtain medical records or information from the Social Security Administration, Medicare contractors, other health care programs, insurers or any government agency to verify eligibility, claims payment information or properly coordinate benefits.					
Employer's Signature <i>Shirley Sneed</i>		Date 1/29/00		Employer's Signature <i>M. Sant-Hen</i>	
				Date 1/29/00	

Please note: Members in a managed care plan who move outside the enrollment area may be eligible to transfer their coverage. Please consult your Account Service Representative for more information.

Call Your Account Service Representative for More Information on This Subject

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Terminating Coverage

Coverage for the **employee (and enrolled dependents)** terminates when:

- The group is terminated for non-payment of premiums or changes.
- The subscriber is no longer eligible for group coverage because he or she no longer meets the eligibility requirements imposed by your group or by us.
- The subscriber (or a covered dependent) is no longer eligible for coverage as a result of misrepresentation or fraud.
- The subscriber (or a covered dependent) misuses the Blue Cross Blue Shield identification card to obtain coverage for which he or she is not eligible under his or her contract. Or, the member misuses the Blue Cross Blue Shield identification card by permitting another person not enrolled for coverage in that plan to attempt to obtain coverage under the contract.
- The subscriber dies. (If the surviving dependents are eligible for continued coverage, a new enrollment request must be submitted.)
- A Medicare-eligible subscriber reaches age 65 and retires (or is already retired). See **Section 7, *When a Member Becomes Eligible for Medicare***.
- The subscriber voluntarily terminates coverage or leaves employment.

Coverage for a **former spouse** terminates when:

- The divorced spouse of the subscriber is no longer eligible for coverage.

Coverage for an **enrolled dependent** terminates when:

- The subscriber's coverage is terminated, as described above.
- The dependent child reaches age 19. There are two exceptions:
 - ◆ Your contract has special provisions for full-time students.
 - ◆ We determine that the dependent child is physically or mentally disabled and incapable of self-support. See **Section 3, *Enrolling Dependents in a Health Plan***.
- The dependent child marries.
- The spouse reaches age 65 and becomes eligible for Medicare. An exception is when the subscriber remains an active employee of a group of 20 or more employees and this contract is chosen for the primary coverage. See **Section 7, *When a Member Becomes Eligible for Medicare***.

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Coverage for a **student dependent** terminates when:

- The subscriber's coverage is terminated, as described above.
- The student reaches the maximum age for coverage, as stipulated in your contract.
- The student marries.
- The student discontinues full-time classes or graduates. In this case, coverage ends on the following November 1 or on the date the student otherwise loses eligibility for student dependent coverage, whichever comes first.

See page 3-6 for more information on the Student Dependent Certification Process.

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An example of a member's voluntary termination follows. You may also use this example for the other terminations shown on pages 5-4 and 5-5.

Blue Cross BlueShield of Massachusetts		Please Read The Instructions Before Filling Out This Form.		Enrollment and Change Form	
An Independent Licensee of the Blue Cross and Blue Shield Association				Please mail to: BCBS, P.O. Box 9145, North Quincy, MA 02171-9145	
1. To Be Filled Out by Your Employer					
Company Name CENTURY INC.			Current Medical Group 0123456		Medical Group Transferring To
Current Group ID Number 012345678			Proposed Effective Date 05 15 2000	Date of Hire 01 1985	Original Group ID Number 0123456
Type of Transaction Add <input type="checkbox"/> Change <input checked="" type="checkbox"/> Cancel <input type="checkbox"/> <small>(Please fill in termination code see instructions)</small>			Remarks: (i.e., qualifying event for a new add, change to family, or further instruction) VOLUNTARY CANCELLATION EFFECTIVE 3/15/00		
2. Tell Us About Yourself (Member 1)					
What product are you selecting? <input type="checkbox"/> Health <input type="checkbox"/> Health & Life <input type="checkbox"/> Health & Life & Disability <input type="checkbox"/> Health & Life & Disability & Vision <input type="checkbox"/> Health & Life & Disability & Vision & Dental <input checked="" type="checkbox"/> Health & Life & Disability & Vision & Dental & Life			Kind of Membership (Medical) Individual <input checked="" type="checkbox"/> Family <input type="checkbox"/>		Kind of Membership (Dental) Individual <input checked="" type="checkbox"/> Family <input type="checkbox"/>
Your First Name ROBERT		M.I. K		Last Name CLARKE	
Street Address / P.O. Box No. 12 PARKER AVENUE		Apt. No. 4		City/Town MALDEN	
Social Security No. 012345678		Home Telephone No. (include area code) (781) 335-3221		Other Insurance Company Name City/State	
Name of PCP City/State		PCP ID Number		Is this your current PCP? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Are you or anyone listed below covered by Medicare? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Part A Effective Date MM DD YYYY		Part B Effective Date MM DD YYYY	
		Medicare No. <input type="checkbox"/> 65+ <input type="checkbox"/> disabled <input type="checkbox"/> ESRD		Actively Working Y / N Retired Y / N <input type="checkbox"/> Yes, date	
* If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.					
3. Tell Us About Your Spouse (Member 2)					
Spouse's First Name		M.I.		Spouse's Last Name	
Social Security No.		Home Telephone No. (include area code)		Other Insurance Company Name City/State	
Name of PCP City/State		PCP ID Number		Is this your current PCP? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Part A Effective Date MM DD YYYY		Part B Effective Date MM DD YYYY		Medicare No. <input type="checkbox"/> 65+ <input type="checkbox"/> disabled <input type="checkbox"/> ESRD	
				Actively Working Y / N Retired Y / N <input type="checkbox"/> Yes, date	
4. Tell Us About Your Dependents (Members 3, 4, and 5)					
Child's First Name		M.I.		Child's Last Name	
Date of Birth MM DD YYYY		Social Security No.		PCP ID Number	
				Name of PCP	
				Is this your current PCP? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Child's First Name		M.I.		Child's Last Name	
Date of Birth MM DD YYYY		Social Security No.		PCP ID Number	
				Name of PCP	
				Is this your current PCP? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Child's First Name		M.I.		Child's Last Name	
Date of Birth MM DD YYYY		Social Security No.		PCP ID Number	
				Name of PCP	
				Is this your current PCP? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<p>The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I authorize Blue Cross and Blue Shield to obtain medical records or information from the Social Security Administration, Medicare contractors, other health care programs, insurers or any government agency to verify eligibility, claims payment information or properly coordinate benefits.</p>					
Robert Clarke Employer's Signature		3/14/00 Date		[Signature] Employer's Signature	
				3/14/00 Date	

Remember: When terminating a member's coverage, indicate the reason for the termination in the Remarks section, such as "Terminate dependent child coverage due to marriage." Both the employee and the employer must sign voluntary termination forms.

Important note: Please review forms carefully before submitting. Be sure to describe the requested transaction in the Remarks section.

Call Your Account Service Representative for More Information on This Subject

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How to Change a Primary Care Physician

(Applies to managed care plans only)

To change a Primary Care Physician (PCP), the employee completes the Enrollment and Change Form and returns it to the address on the form. **Note:** Members may also call their Customer Service Center or Physician Selection Service at 1-800-821-1388 to make this change over the phone.

The change will be effective on the day Blue Cross Blue Shield receives the member's request under any of the following plans: **HMO Blue, Blue Choice, HMO Blue Value, and HMO Blue Value Plus.**

The change will be effective on the 1st day of the month following the date Blue Cross Blue Shield receives the member's request under any of the following plans: **HMO Blue, HMO Blue New England, Blue Choice New England, and Network Blue New England.** The member should consult with their new PCP for referrals for continued care.

The following *Enrollment and Change Form* shows how to change a member's PCP.

Blue Cross Blue Shield of Massachusetts		Please Read The Instructions Before Filling Out This Form.		Enrollment and Change Form	
An Equal Opportunity Employer of the Blue Cross Blue Shield of Massachusetts		Please mail to: BCBS, P.O. Box 8145, North Quincy, MA 02171-8145			
1. To Be Filled Out by Your Employer					
Company Name <i>Alpha Company</i>		Current Medical Group <i>0123456</i>		Medical Group Transferring To	
Current Medical Group <i>012345678</i>		Group ID <i>0123456</i>		Transfer Group Transferring To	
Type of Transaction: <input type="checkbox"/> Add <input checked="" type="checkbox"/> Change <input type="checkbox"/> Cancel <input type="checkbox"/> Termination Reason: (i.e., qualifying event for a new add, change to family, or further instructions) <i>Change PCP for Jessica Johnson</i>					
2. Tell Us About Yourself (Member 1)					
What gender are you? <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		Married? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Kind of Membership (Member) <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family	
Your First Name <i>Zachary</i>		Last Name <i>Johnson</i>		Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
Street Address <i>20 Prospect Road</i>		City <i>Edgartown</i>		State <i>MA</i>	
Zip <i>02539</i>		Phone <i>(508) 555-1212</i>		Other Insurance Company Name	
Social Security No. <i>012345678</i>		Medicare No. <i>133J12345</i>		Is this your current PCP? (Mark A, F, or N) <input checked="" type="checkbox"/>	
Name of PCP <i>Dr. McDaniel</i>		City/State <i>Edgartown, MA</i>		PCP # Number <i>113J12346</i>	
Part A Effective Date		Part B Effective Date		Medicare No.	
Acting Working Y/N		Retired Y/N		If you, date	
<small>* If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.</small>					
3. Tell Us About Your Spouse (Member 2)					
Spouse's First Name <i>Jessica</i>		Spouse's Last Name <i>Johnson</i>		Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
Social Security No. <i>023456789</i>		Phone <i>(508) 555-1212</i>		Other Insurance Company Name	
Name of PCP <i>Dr. Jacqueline Ives</i>		City/State <i>Edgartown, MA</i>		PCP # Number <i>113J12346</i>	
Part A Effective Date		Part B Effective Date		Medicare No.	
Acting Working Y/N		Retired Y/N		If you, date	
4. Tell Us About Your Dependents (Members 2, 4, and 5)					
Child's First Name		Child's Last Name		Sex	
Date of Birth		Social Security No.		PCP # Number	
Name of PCP		City/State		Is this your current PCP? (Mark A, F, or N)	
Child's First Name		Child's Last Name		Sex	
Date of Birth		Social Security No.		PCP # Number	
Name of PCP		City/State		Is this your current PCP? (Mark A, F, or N)	
Child's First Name		Child's Last Name		Sex	
Date of Birth		Social Security No.		PCP # Number	
Name of PCP		City/State		Is this your current PCP? (Mark A, F, or N)	
The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I authorize Blue Cross and Blue Shield to obtain medical records or information from the Social Security Administration, Medicare contractors, other health care programs, insurers or any government agency to verify eligibility, claims payment information or properly coordinate benefits.					
Employee Signature <i>[Signature]</i>		Date <i>1/15/03</i>		Member Signature <i>[Signature]</i>	

Call Your Account Service Representative for More Information on This Subject