



## SUBSCRIBER IFP PLAN CHANGE REQUEST FORM

### INSTRUCTIONS:

Complete this form in ink. Do not include dues/premiums. You can use this form to transfer YouthCare subscribers as well as adult subscribers. A long form C-12900-AE is required when coming from Blue Shield Group Health Plan, Guaranteed Issue Plan, Individual Conversion Plan or Post-MRMIP Product Plan coverage, or if you would like to add a new family member to your plan. Please send your completed application to: Blue Shield, P.O. Box 629013, El Dorado Hills, CA 95762-9013. Or fax it back to (916) 350-7500.

### I - A. - INDICATE THE MEDICAL PLAN YOU WOULD LIKE TO CHANGE TO

- PPO PLAN 500   
  PPO PLAN 750   
  PPO PLAN 1500   
  PPO PLAN 2000   
  PPO PLAN 5000   
  PPO SAVINGS PLAN 2400  
 PPO SAVINGS PLAN 4800   
  ACTIVE CHOICE PLAN 600   
  ACCESS + HMO

### I - B. - TIER RECONSIDERATION

- CHECK HERE IF YOU WOULD LIKE TO BE CONSIDERED FOR BLUE SHIELD'S LOWEST RATES.

### II. - CHECK ONE BOX BELOW IF YOU WOULD LIKE TO ADD DENTAL COVERAGE TO YOUR HEALTH PLAN

- DENTAL PPO   
  DENTAL HMO

If you are applying for the Dental HMO, you must choose a Dental Center from the Blue Shield Dental HMO Dental Center Directory (available at [www.mylifepath.com](http://www.mylifepath.com) or call (800) 431-2809). The Dental Center you choose will provide or arrange dentalcare for you and all covered dependents.

Dental Center #: \_\_\_\_\_ Dental Center Name: \_\_\_\_\_

### III. - SUBSCRIBER INFORMATION

BLUE SHIELD SUBSCRIBER ID	FIRST NAME	MI	LAST NAME
MARRIED YES <input type="checkbox"/> NO <input type="checkbox"/>	HOME PHONE	WORK PHONE	
			CHECK HERE IF THIS IS A NEW ADDRESS WITHIN THE LAST 6 MONTHS <input type="checkbox"/>
MAILING ADDRESS		CITY	STATE      ZIP CODE
BILLING ADDRESS		CITY	STATE      ZIP CODE
COUNTY OF RESIDENCE	SOCIAL SECURITY NUMBER	OTHER NAME UNDER WHICH SUBSCRIBER HAS RECEIVED CARE	

### IV. - PLEASE COMPLETE THIS SECTION IF YOU ARE A CURRENTLY ENROLLED MEMBER REQUESTING A PLAN CHANGE

RELATION	CONSIDER FOR SEPARATE YOUTHCARE	FIRST NAME	MI	LAST NAME (IF DIFFERENT FROM ABOVE)	SOCIAL SECURITY #	DATE OF BIRTH MO. DAY YR.
SELF: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Not Applicable				- -	- / - / -
<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE	Not Applicable				- -	- / - / -
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> YES <input type="checkbox"/> NO				- -	- / - / -
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> YES <input type="checkbox"/> NO				- -	- / - / -
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> YES <input type="checkbox"/> NO				- -	- / - / -

### V. - Please answer the following questions for yourself and EACH family member listed above.

(If you need additional space, please attach a separate sheet of paper listing the required information. Be sure to identify the family member.)

#### 1. Have you or any covered family member had any condition that resulted in a surgery or hospitalization within the past two years? YES NO

List first name of family member(s):	Condition(s) diagnosed:	Type(s) of treatment(s) received:	Date treatment began: - / - / -	Date treatment ended: - / - / -	Full name and address of physician providing treatment:
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#### 2. Other than routine physical exams with normal findings, have you or any covered family member had any medical consultation, medical treatment or testing during the past six months? YES NO

List first name of family member(s):	Condition(s) diagnosed:	Was follow-up required? YES <input type="checkbox"/> NO <input type="checkbox"/> Please list Details:	Full name and address of physician providing treatment:
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#### 3. Are you or any covered family member currently taking prescription drugs? YES NO

List first name of family member(s):	Condition(s) diagnosed:	Name of medication(s)
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#### 4. Are you or any family member covered or not covered under your plan, currently pregnant or under treatment for surrogate pregnancy? YES NO

List first name of family member(s):	Relationship to subscriber:
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#### 5. Do you or any family member have any other condition that may result in a medical consultation, medical treatment, testing, surgery or hospitalization in the future? YES NO

List first name of family member(s):	Type of condition(s):	Type(s) of future treatment(s)	Estimated date of treatment(s): - / - / -	Please provide complete details:
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**VI. – ACCESS+ HMO ONLY: Complete this section if you are applying for Access+ HMO**

The Blue Shield ACCESS+ HMO is available only in those Plan Service areas specified in the Blue Shield HMO Physician and Hospital Directory. Subscribers must live or work in a Plan Service Area. You must select a Personal Physician for yourself and each of your eligible family members from the list of Personal Physicians in the Blue Shield HMO Physician and Hospital Directory for your service area. You may choose the same or a different Blue Shield HMO Personal Physician for each family member. Be sure to include each Personal Physician's provider number as listed in the directory. If you have any questions about completing this section, please contact your Blue Shield Agent.

RELATION	FIRST NAME	FIRST	PERSONAL PHYSICIAN NAME MI	LAST	PROVIDER #	CURRENT PATIENT
SELF: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE						<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE						<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER						<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER						<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER						<input type="checkbox"/> YES <input type="checkbox"/> NO

Do all applying family members reside with applicant? YES  NO  If No, identify the individual and give address: \_\_\_\_\_

SUBSCRIBER'S OCCUPATION AND EMPLOYER	EMPLOYER ADDRESS	CITY	ZIP
SPOUSE'S OCCUPATION AND EMPLOYER	EMPLOYER ADDRESS	CITY	ZIP

**VII. – AUTHORIZATIONS, TERMS & CONDITIONS**

In addition to the terms & conditions for IFP plan coverage previously agreed upon, the following apply. Please read carefully. Your authorization and signature is required below:

1. If your application to change plans is approved, the Underwriting Department will assign an effective date of the transfer. Until you are approved, you should maintain your current coverage. Continue making payments on your current plan until you receive notification that your change request has been approved.
2. The rates and benefit plan option approved may vary depending on underwriting determination. If you do not qualify for the benefit plan option you selected, you may be enrolled in a higher deductible plan or a higher rate may apply. You will be notified of your benefit plan and rate by the Underwriting Department. You have the option to transfer back to your previous plan and rate at that time.
3. Please be advised, the rate for your family plan is based on the cumulative health risk of each member. If you are considering requesting that your family contract be split into separate contracts and grouping the healthiest family members together, please be aware that separate contracts and rates could result in an even higher total rate than the original contract.
4. If approved, this plan change Application, together with the original Application for Blue Shield Individual and Family Health Plans, evidence of coverage and health service agreement/certificate of insurance and policy, any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage. Your agent cannot approve this Application for coverage or change any terms or conditions of coverage.
5. HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by a health insurance company or health care service plan as a condition of obtaining health coverage.

**6. AUTHORIZATION FOR DISCLOSURE OF PERSONAL INFORMATION**

By signing below, you authorize any "provider of care," insurer, health plan, or your Blue Shield agent or broker, to disclose to Blue Shield of California or Blue Shield of California Life and Health Insurance Company (individually or collectively referred to as "Blue Shield"), or its representatives, and vice versa, all "medical information" (as those terms are defined in the California Civil Code) regarding you and your applying family members, including medical information regarding substance abuse or mental/emotional conditions. This information may be used for the purposes of evaluating this application, determining eligibility and claims for benefits, quality assurance, peer review, or administrative functions reasonably related to executing and managing this Agreement/Policy. In addition, you authorize Blue Shield to obtain personal and medical record information (as those terms are defined in the California Insurance Code) from an institutional source or an insurance support organization that gathers this type of information, for the purposes of determining eligibility for coverage. This authorization will remain valid as follows: (1) for 30 months from the date of authorization for the purpose of processing the application, a policy reinstatement, or a request for change in policy benefits; and (2) for all other activities under the policy, for the term of the coverage or for as long as may be necessary for processing of claims incurred during the term of coverage. I understand that I am entitled to a copy of this form and that a photocopy is as valid as the original.

7. Shield Spectrum PPO Plan 5000 and Active Choice Plan 600 are provided by and underwritten by Blue Shield Life & Health Insurance Company.

**Process to Authorize Blue Shield to Release Personal Information to Others:** If you would like to authorize your spouse or a third party to access your personal health information, please complete the form titled "Authorization for Blue Shield to Disclose Personal & Health Information to a Third Party". To obtain this form go to "mylifepath.com" or call 1-800-431-2809.

I have read the summary of benefits and understand the terms and conditions of coverage for the benefit plan I am applying to change to. I understand and agree to each of them. I alone am responsible for the accuracy and completeness of the information provided on this plan change application. I understand that neither I, nor any family members, will be eligible for coverage if any information is false or incomplete. I also understand that if coverage is issued, it may be revoked upon such a finding.

_____ TODAY'S DATE (REQUIRED)	X _____ SIGNATURE OF SUBSCRIBER (OR LEGAL GUARDIAN)	_____ PRINT NAME (AND RELATIONSHIP IF APPLICANT IS A MINOR)
_____ TODAY'S DATE (REQUIRED)	X _____ SIGNATURE OF SUBSCRIBER'S SPOUSE (IF APPLYING)	_____ PRINT NAME
_____ TODAY'S DATE (REQUIRED)	X _____ SIGNATURE OF FAMILY MEMBER AGE 18 AND OVER (IF APPLYING)	_____ PRINT NAME

**VIII. – IF THIS APPLICATION IS SUBMITTED THROUGH A PRODUCER, THE PRODUCER MUST COMPLETE THE AREA BELOW.**

PRODUCER #	TELEPHONE # ( )	FAX # ( )	<b>PRODUCER'S CERTIFICATION</b> 1. Are you aware of any information not disclosed in this application of health, which may have a bearing on this risk? <input type="checkbox"/> Yes, explain <input type="checkbox"/> No 2. Did you see the subscriber and did you ask each question in this application exactly as set forth and are the answers recorded exactly as given to you? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Who completed this application? <input type="checkbox"/> Producer <input type="checkbox"/> Subscriber
PRODUCER'S NAME			
PRODUCER'S ADDRESS			
CITY	STATE	ZIP	
PRODUCER'S EMAIL ADDRESS	PRODUCER SIGNATURE X _____	TODAY'S DATE (Required)	