10455 Mill Run Circle
Owings Mills, MD 21117

CareFirst BlueCross BlueShield

INDIVIDUAL MARKET DIVISION
AUTHORIZATION TO CHANGE FORM

This is not an application for insurance

PLEASE COMPLETE ALL APPLICABLE SPACES ON THIS FORM. SIGN AND RETURN TO THE ADDRESS SHOWN ABOVE.

I. SUBSCRIBER INFORMATION

Your Last Name First Name Middle Name SSN/Subscriber Identificatin Number

Number & Street Address State Zip Code

Male ❑ Female ❑ Married ❑ Partner ❑ Single ❑ Widowed ❑ Divorced ❑ Separated ❑

Your Date of Birth ___/___/___ Spouse's/Partner's Date of Birth ___/___/___

Home Phone (____) _____ – _____ Business Phone/Extension (____) _____ – _____

II. OTHER HEALTH INSURANCE COVERAGE INFORMATION

PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR OTHER INSURANCE YOU OR YOUR FAMILY MAY HAVE:

IF CURRENTLY COVERED BY BLUE CROSS AND BLUE SHIELD:

Membership Number	Spouse's Number (if any)	Location of Blue Cross & Blue Shield Plan: City and State	

IF COVERED BY ANOTHER HEALTH INSURANCE PLAN:

Policy Number	Name of Insured	Name of Insurance Company	Employer

IF YOU OR ANY OF YOUR DEPENDENTS ARE COVERED BY MEDICARE, PLEASE PROVIDE:

Name	Hospital Insurance Claim Number	Hospital Insurance Effective Date	Medical Insurance Effective Date

III. DEPENDENT ADDITION

A. NEWBORN

	Last Name	First Name	MI	Date of Birth	Social Security Number
M ❑ F ❑					

B. ADOPTED DEPENDENT

	Last Name	First Name	MI	Date of Birth	Social Security Number
M ❑ F ❑					
	Date of Adoption or Legal Custody:*				

C. CUSTODIAL DEPENDENT

	Last Name	First Name	MI	Date of Birth	Social Security Number
M ❑ F ❑					
	Date of Custody*:				

* PLEASE ATTACH COPY OF LEGAL DOCUMENT PROVING CUSTODY.

IV. COVERAGE

ADD	REMOVE
❑ Dental ❑ Vision	❑ Dental ❑ Vision

V. CHANGES IN MEMBERSHIP/COVERAGE

A. REMOVE

Last Name	First Name	MI	Date of Birth	Social Security Number	Effective Date

REASON ❑ Death ❑ Divorce ❑ Separation ❑ Dependent Removal ❑ Other _____
Please Specify

B. SPLIT MEMBERSHIP/CONVERT

1) Set up for continuous coverage

Removed Dependent's Name	Type of Coverage	Social Security Number	Effective Date

REASON ❑ Death ❑ Divorce ❑ Separation ❑ Dependent Removal ❑ Other _____
Please Specify

2) Change type of coverage

Policy Holders Name	IND, P& C, H&W, Family	Effective Date	SSN/Subscriber Identification Number

FROM_____ TO_____

3) ❑ Dependent converting to his/her own policy: Name:_____
❑ Current subscriber terminating and spouse to become subscriber/policyholder

VI. INCREASE DEDUCTIBLE TO

❑ $200 ❑ $500 ❑ $1,000 ❑ $1,700 ❑ $2,500 ❑ $5,000 ❑ $10,000 Effective Date:_____

HIPPA ❑ $400 or ❑ $800

VII. NAME CHANGE (Provide documentation)

From:_____
Previous Name

To:_____
Present Name

Date:_____

REASON FOR NAME CHANGE
❑ Marriage ❑ Divorce ❑ Other _____
_____

Policy Holder's Signature:_____
DO NOT PRINT

Dependent's Signature:_____
If converting or spliting Date

PLEASE BE SURE YOU HAVE FILLED OUT THIS FORM COMPLETELY

ALL PROGRAMS WILL BE BILLED ON A QUARTERLY BASIS

INTERNAL USE ONLY

Apply the changes noted in this document to program: _____

CIA/IACS#:_____

EE# _____

Effective Date of Changes: _____