

CHANGE NOTICE

PLEASE PRINT

REFER TO THE INSTRUCTIONS BELOW.

EMPLOYER: PLEASE COMPLETE THIS SECTION

GROUP NAME	GROUP NO.	SECTION NO.		
ADDRESS	CITY	STATE	ZIP	EMPLOYER PHONE

EMPLOYEE: PLEASE COMPLETE THIS SECTION

LAST NAME	FIRST NAME	INITIAL
DATE OF BIRTH	IDENTIFICATION NO.	SOCIAL SECURITY NO.

IF THERE IS A CHANGE IN YOUR NAME OR ADDRESS, FILL IN BELOW

PREVIOUS LAST NAME	NEW LAST NAME	FIRST NAME	INITIAL	
NEW STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE
REASON FOR CHANGE: <input type="checkbox"/> MARRIAGE <input type="checkbox"/> DIVORCE <input type="checkbox"/> OTHER				EFFECTIVE DATE OF CHANGE / /

PLEASE INDICATE COVERAGE(S) AFFECTED

- MEDICAL DENTAL
 OTHER (Specify):

PCP CHANGE

Indicate new PCP#: _____ (Name) _____
Reason: _____
Effective Date: _____

IF THERE ARE CHANGES IN THE COVERAGE(S) OF YOUR DEPENDENT(S), FILL IN BELOW

ADD	CANCEL	REASON & DATE	
<input type="checkbox"/> Spouse only	<input type="checkbox"/> Spouse only	<input type="checkbox"/> Marriage	____/____/____
<input type="checkbox"/> Child(ren) only	<input type="checkbox"/> Child(ren) only	<input type="checkbox"/> Divorce	____/____/____
<input type="checkbox"/> Spouse & Child(ren)	<input type="checkbox"/> Spouse & child(ren)	<input type="checkbox"/> Death of Spouse	____/____/____
	<input type="checkbox"/> Entire Contract	<input type="checkbox"/> Birth	____/____/____
		<input type="checkbox"/> Adoption	____/____/____
		<input type="checkbox"/> Employee's request/left employer	____/____/____
		<input type="checkbox"/> Other Reason: (Describe)	____/____/____

REQUESTED EFFECTIVE DATE ____/____/____

LAST NAME	FIRST NAME	INITIAL	GENDER	DATE OF BIRTH MONTH/DAY/YEAR	STUDENT?	SOCIAL SECURITY NO.	PCP NO.
SPOUSE			M / F	/ /	YES NO		
CHILD			M / F	/ /	YES NO		
CHILD			M / F	/ /	YES NO		
CHILD			M / F	/ /	YES NO		

IF THERE IS A CHANGE IN YOUR OTHER HEALTH INSURANCE INFORMATION, FILL IN BELOW

Is anyone named in this application eligible for Medicare coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Person(s)	Medicare Card No. _____	Part A (Hosp) Effective Date _____	Part B (Med.) Effective Date _____	Part D (Rx) Effective Date _____
Reason: <input type="checkbox"/> ESRD <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> Retired	Part D (Rx) Insurance Co. _____	Self _____	Spouse _____	Dependent _____
Does anyone named in this application have other group insurance coverage, or BCBSWI coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes Complete the following information in this section:	Type of Coverage <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Drug			
Individual's Employer _____	Employer's Phone _____			
Name under which policy is listed _____	Social Security No. _____	<input type="checkbox"/> Single Plan	Effective Date _____	Cancellation Date _____
Name of Insurance Company _____	City _____	State _____	<input type="checkbox"/> Family Plan	
Insurance Company's Phone _____	Policy I.D. No. _____	Group No. _____		

IF YOU ARE TRANSFERRING COVERAGE, PLEASE COMPLETE

PREVIOUS MEDICAL GROUP NO.	PREVIOUS MEDICAL SECTION NO.	PREVIOUS DENTAL GROUP NO.	PREVIOUS DENTAL SECTION NO.	PREVIOUS PKG. CODE		
If the Individual being added had coverage in the last 12 months, please complete the following or attach a certificate of credible coverage.						
Name of Covered Individual	Name of Insurance Company	Type of Coverage (family or single)	Type of Plan (medical or dental)	Continuing Coverage	Effective Date of Coverage	Cancellation Date
		<input type="checkbox"/> Family <input type="checkbox"/> Single	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Family <input type="checkbox"/> Single	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Yes <input type="checkbox"/> No		

EMPLOYEE SIGNATURE (required for name, address, dependent, PCP or COB change)

I HEREBY APPLY FOR ENROLLMENT SUBJECT TO TERMS AND CONDITIONS. IMPORTANT: PLEASE READ REVERSE SIDE

X

DATE SIGNED:

EMPLOYER SIGNATURE (required for transfer of coverage)

X

DATE SIGNED:

www.bluecrosswisconsin.com

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INSTRUCTIONS

The **Employer** should complete the Employer Information section of the form, indicating the Employer's name, address, phone number, Group Number, Section Number, and Package Code. The **Employee** should complete the Employee Information section of the form, indicating the last name, first name, middle initial, birth date, identification number and Social Security number. Once these sections have been completed, the Employer or Employee should indicate the coverage(s) that will be affected by checking the appropriate boxes.

For each item to be changed, the box next to the type of change should be checked. All the requested information for the change must be provided in full. Special note should be made for the following changes:

Name Change

The Employee's new name should be entered in the Employee Information section at the top of the form. The previous name should be indicated in the Name Change section of the form.

Dependent Change

Please check the boxes to indicate if the change is to add or terminate coverage for spouse only, children only or spouse and children. Also check the box to indicate what the new status should be. The reason and effective date for the change should be indicated. If adding coverage for spouse and/or children, their complete name(s) and date(s) of birth should be written in the spaces provided.

PCP Change

Please check the box(es) to indicate a request for change in the Clinic/Provider. Indicate the new PCP information.

Transfer of Coverage

If transferring the Employee's coverage to a new group or section number, the **Employer** should indicate the Employee's new group number, section number and package code in the Employer Information section at the top of the form. The **Employer** should indicate the Employee's previous group number, section number and package code in the Transfer of Coverage section of the form.

The **Employee** must sign the form for any change in Name, Address, Dependent, Clinic/Provider or Coordination of Benefits. The **Employer** must sign the form for a Transfer of Coverage or Change in Schedule of Benefit Classification.

HOW TO SUBMIT YOUR CHANGE FORM:

The Change Notice can be submitted to:

By Mail:

Blue Cross Blue Shield of Wisconsin or CompCareBlue

P.O. Box 1975

Fond du Lac, WI 54936-1975

By Fax:

Fax: (920) 923-7572

By Email:

enrollmentservices@bcbswi.com

Dental Changes:

The Change Notice form can be submitted to:

DentalBlue

P.O. Box 2300

Fond du Lac, WI 54936-2300

By Fax:

Fax: (920) 923-7572