BlueCross BlueShield Minnesota

INDIVIDUAL COMMERCIAL CHANGE FORM

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.

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

❑ Addendum attached

Contract holder's identification number: _____ **Date of birth:** _____
mm/dd/yyyy

Contract holder's name: _____

Preferred Email address: _____ **Alternate Email address:** _____

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. Requested termination date: _____
mm/dd/yyyy

Reason: ❑ Death ❑ Medicare ❑ Other Insurance ❑ Military ❑ Other _____

Note: Checking this box will cancel the entire contract. Please use section D to delete the contract holder, or section E to delete dependents.

B. Address/Phone change

Preferred telephone number: (_____) _____ Telephone type: ❑ home ❑ cell ❑ work

Alternate telephone number: (_____) _____ Telephone type: ❑ home ❑ cell ❑ work

❑ Change my mailing address to: _____

❑ Change my billing address to: _____

Note: Only check and provide a billing address if different from mailing address.

C. Name change

From _____ to _____

Reason (required) _____ Event date _____
mm/dd/yyyy

D. Deletion of contract holder: Please check the reason and provide the event date.

❑ Death _____ mm/dd/yyyy ❑ Medicare _____ mm/dd/yyyy ❑ Divorce _____ mm/dd/yyyy

❑ Other _____ Reason Event date _____ mm/dd/yyyy

Note: Complete section G if your family member(s) are requesting replacement coverage.

E. Deletion of family member(s)

Delete coverage for the following family member(s): _____
Name of family member(s)

Reason (required): _____ Date of event _____
mm/dd/yyyy

Note: If you are deleting coverage for your family member(s) due to divorce, they may request replacement coverage. Section G must be completed.

Signature required – see reverse side – OVER

F. Request for 36 month Continuation of Coverage for a dependent that is no longer eligible due to reaching age 26.

Family Member's Name: _____

❑ I am requesting a 36 month continuation of coverage on this contract. (Contract holder's signature required.)

G. Request replacement coverage for dependent(s):

List each dependent individually who is requesting replacement coverage and their Social Security Number (SSN). Please attach addendum if more than one dependent is requesting replacement coverage under their own name. Under certain plans, persons under the age of 20 applying as the contract holder can only have single coverage.

❑ There is more than one dependent requesting replacement coverage.

New Contract holder's name: _____ SSN: _____

Address if different from current address: _____

Dependents to retain coverage under the new contract holder's name:

_____

_____

_____

_____

_____

_____

This form may be used only to make the changes listed 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 my new benefit plan may not have the same benefits, networks, or other terms and conditions as my previous plan. If this form is completed as an electronic form, both parties agree to conduct this transaction electronically.

This information is also available in other ways to people with disabilities by calling customer service at (651) 662-8000 (voice), or 1-800-382-2000 (toll free).

For TTY: Call (651) 662-8700, or 1-888-878-0137 (TTY), or 711, or through the Minnesota Relay direct access numbers at 1-800-627-3529 (TTY, voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (Speech-to-Speech) Hours: 7:00 a.m. to 8 p.m., Central Time, Monday through Friday.

Attention, if you want free help translating this information, call the above number.
Atencion, si desea recibir asistencia gratuita para traduca esta informacion, llame al numero que aparece mas arriba.

Contract holder's signature **X** _____ Date_____
mm/dd/yyyy

Spouse/Domestic Partner/Dependent's signature **X** _____ Date_____
mm/dd/yyyy

Parent/Legal guardian or Guarantor's signature **X** _____ Date_____
(if contract holder is a minor) mm/dd/yyyy

Preferred telephone number: (_____)_____ Alternate telephone number: (_____)_____

Telephone type: ❑ home ❑ cell ❑ work Telephone type: ❑ home ❑ cell ❑ work

Send to: Blue Cross and Blue Shield of Minnesota, P.O. Box 64024, St. Paul, Minnesota 55164-0024
Fax to: 651-662-6439 Email to: **Incoming_Service_Center@bluecrossmn.com**.
Please retain your fax copy until you receive notice of action.