



# Request for Change in Membership

WITH BLUE CROSS AND BLUE SHIELD OF OKLAHOMA • P.O. BOX 3283, TULSA, OKLAHOMA 74102-3283  
A Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

CHECK THE BOX THAT APPLIES:  
 Group Health only  
 Group Dental only  
 Group Health and Group Dental

PLEASE PRINT IN INK OR TYPE  NAME OR ADDRESS CHANGE  TERMINATION  ADDING/DROPPING DEPENDENTS  
CHECK APPROPRIATE BOX(ES): COMPLETE ITEMS 1 THROUGH 3, & 7 COMPLETE ITEMS 1 THROUGH 4, & 7 COMPLETE ITEMS 1 THROUGH 3 & 5 THROUGH 7

<b>1</b>	MEMBER'S NAME (LAST, FIRST, MIDDLE)		<b>NAME CHANGE</b>		NEW NAME (LAST, FIRST)	RESIDENCE TELEPHONE A/C
	ADDRESS (STREET OR BOX NO.)		(CITY)	(STATE)	(ZIP)	COUNTY
<b>2</b>	SUBSCRIBER ID NO.		PRESENT GROUP NO.		I AM EMPLOYED BY (NAME OF COMPANY, CITY, STATE)	
	S <input type="text"/>					
<b>3</b>	SUBSCRIBER ID NO.		PRESENT GROUP NO.		I AM EMPLOYED BY (NAME OF COMPANY, CITY, STATE)	
	S <input type="text"/>					
<b>4</b>	<b>TERMINATION</b>		<input type="checkbox"/> I REQUEST TERMINATION OF COVERAGE AS I AM NO LONGER EMPLOYED AS OF		<input type="checkbox"/> I REQUEST TERMINATION OF COVERAGE WITHOUT LEAVING EMPLOYMENT AS OF	
			Mo. Day Yr.		Mo. Day Yr.	

## 5 ADDING/DROPPING DEPENDENTS

CHANGE MY MEMBERSHIP TO:			
<input type="checkbox"/> <b>EMPLOYEE ONLY</b>	<input type="checkbox"/> <b>EMPLOYEE AND SPOUSE</b>	<input type="checkbox"/> <b>EMPLOYEE AND UNMARRIED CHILDREN</b>	<input type="checkbox"/> <b>EMPLOYEE, SPOUSE AND UNMARRIED CHILDREN</b>
PLEASE COMPLETE, READ AND SIGN ITEMS 1 THROUGH 3, AND 5 THROUGH 7	PLEASE COMPLETE, READ AND SIGN ITEMS 1 THROUGH 3, AND 5 THROUGH 7	PLEASE COMPLETE, READ AND SIGN ITEMS 1 THROUGH 3, AND 5 THROUGH 7	PLEASE COMPLETE, READ AND SIGN ITEMS 1 THROUGH 3, AND 5 THROUGH 7
IF DEPENDENT ADDED OR DROPPED, GIVE REASON AND DATE OF: <input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> BIRTH <input type="checkbox"/> MARRIAGE <input type="checkbox"/> ADOPTION <input type="checkbox"/> LOSS OF OTHER COVERAGE <input type="checkbox"/> OTHER (Need adoption papers) (Provide certificate of coverage) (Give reason)			
FULL NAME OF SPOUSE (FIRST, MIDDLE, LAST)		DATE OF BIRTH	SPOUSE'S SOCIAL SECURITY NO.
<input type="checkbox"/> ADD <input type="checkbox"/> DROP		Mo. Day Yr.	<input type="text"/>
IF DEPENDENT OR SPOUSE IS NOW BCBS MEMBER:	GROUP NO.	AGREEMENT NO. (SUBSCRIBER ID NO.)	SPOUSE'S PLACE OF EMPLOYMENT
GROUP NAME			Mo. Day Yr.
DEPENDENT'S FULL NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO EMPLOYEE		DATE OF BIRTH
<input type="checkbox"/> ADD <input type="checkbox"/> DROP	<input type="checkbox"/> SON/STEP-SON <input type="checkbox"/> DAUGHTER/STEP-DAUGHTER <input type="checkbox"/> OTHER (DESCRIBE)		Mo. Day Yr.
SOCIAL SECURITY NUMBER	DEPENDENT'S PRIMARY CARE PHYSICIAN (PHYSICIAN'S FULL NAME) (IF APPLICABLE)	IS THIS YOUR DEPENDENT'S CURRENT PHYSICIAN	PCP NUMBER FROM PROVIDER DIRECTORY
<input type="text"/>		<input type="checkbox"/> YES <input type="checkbox"/> NO	PCP- <input type="text"/>
IS THIS DEPENDENT A NATURAL CHILD, STEP-CHILD, OR ADOPTED CHILD? IF NO, ATTACH COPY OF SIGNED COURT DECREE. <input type="checkbox"/> YES <input type="checkbox"/> NO			
IS THIS DEPENDENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO			
ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF DEPENDENT IS OVER AGE 19, IS THE DEPENDENT A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY? IF YES, COMPLETE THE FOLLOWING: <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME OF COLLEGE:		CITY/STATE	HOURS ENROLLED

DEPENDENT'S FULL NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH
<input type="checkbox"/> ADD <input type="checkbox"/> DROP	<input type="checkbox"/> SON/STEP-SON <input type="checkbox"/> DAUGHTER/STEP-DAUGHTER <input type="checkbox"/> OTHER (DESCRIBE)	Mo. Day Yr.
SOCIAL SECURITY NUMBER	DEPENDENT'S PRIMARY CARE PHYSICIAN (PHYSICIAN'S FULL NAME) (IF APPLICABLE)	IS THIS YOUR DEPENDENT'S CURRENT PHYSICIAN
<input type="text"/>		<input type="checkbox"/> YES <input type="checkbox"/> NO
IS THIS DEPENDENT A NATURAL CHILD, STEP-CHILD, OR ADOPTED CHILD? IF NO, ATTACH COPY OF SIGNED COURT DECREE. <input type="checkbox"/> YES <input type="checkbox"/> NO		
IS THIS DEPENDENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF DEPENDENT IS OVER AGE 19, IS THE DEPENDENT A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY? IF YES, COMPLETE THE FOLLOWING: <input type="checkbox"/> YES <input type="checkbox"/> NO		
NAME OF COLLEGE:		CITY/STATE
HOURS ENROLLED		

<b>6</b>	DOES ANYONE LISTED ON THIS APPLICATION HAVE HEALTH INSURANCE, MEDICARE OR MEDICAID, OR HAS ANYONE LOST COVERAGE DURING THE LAST 2 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION: INSURANCE COMPANY NAME	
INSURED'S NAME		MEMBER ID/SUBSCRIBER NO./CASE NO.	GROUP NO./POLICY NO.	PERSONS COVERED <input type="checkbox"/> APPLICANT <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENTS LISTED ON APPLICATION <input type="checkbox"/> OTHER
HAS COVERAGE TERMINATED? <input type="checkbox"/> YES, ON <input type="checkbox"/> NO		IF NO, WILL YOUR CURRENT COVERAGE BE TERMINATED IF THIS COVERAGE IS APPROVED? <input type="checkbox"/> YES, CURRENT COVERAGE WILL BE TERMINATED <input type="checkbox"/> NO, I WILL KEEP BOTH COVERAGES		NOTE: IF MORE THAN (1) ONE INSURANCE POLICY, PLEASE PROVIDE THE INFORMATION ON ITEM 6 FOR ADDITIONAL INSURANCE CARRIERS ON A SEPARATE PIECE OF PAPER AND ATTACH IT TO THIS APPLICATION.

GROUP NO.	F/C AGREEMENT NO.	F/C CODE	QWA CODE	WVA CODE EXP. DATE	GROUP ID	DIV CODE	CROSS-REF AGREEMENT NO.
COB CODE	CO CODE	INVOICE NO.	MS CODE	MSC DATE	CHAR. CODE DATE	SUB BASIC CHAR.	DEP. BASIC CHAR.
SPLIT MEMBERSHIP CHANGES:		SUB DENTAL CHAR.		DEP. DENTAL CHAR.			
Please do not terminate the dependents under this membership _____, until the new membership has been established under ID number _____.							
APPROVED BY			DATE PROCESSED		APPROVAL DATE (EFFECTIVE DATE)		DROP EFFECTIVE DATE

## 7 AGREEMENT AND SIGNATURES (READ, SIGN AND DATE)

There is a Preexisting Condition limitation on the coverages available from the Plan (except for Dental coverage). A Preexisting Condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date. A Preexisting Condition will not apply to pregnancy or to a newborn or adopted child under age 18, provided the child becomes covered under the Contract/Agreement within 31 days of birth or adoption. The length of the Preexisting Condition limitation period is 12 months after the enrollment date for Timely and Special Enrollees, and 18 months for Late Enrollees. The Preexisting Condition limitation waiting period may be reduced by the number of days you (and/or your spouse, and/or dependents) were covered under a prior health insurance plan(s) should there be no more than a 63 day break in coverage, excluding your waiting period, if any. To do this you may request a Certificate of Coverage form from the prior health plan(s) or issuer and send it to our Enrollment Services Department. After the amount of prior creditable coverage has been determined, we will notify you of Preexisting Condition credit based on your prior coverage. Please attach your Certificate of Coverage, if you currently have one.

I, on behalf of myself and any persons whose names appear on this application, hereby apply for coverage from Blue Cross and Blue Shield of Oklahoma (called "the Plan") as stated in this application. I agree that if my application is accepted, coverage will be effective on the effective date assigned by the Plan. I further agree that any changes in my coverage will not become effective until approved by the Plan. I understand that this is an application only, and I should not cancel any existing coverage until I am notified of acceptance, in writing, by the Plan. If I have selected Blue Cross and Blue Shield of Oklahoma coverage, I appoint the Board of Directors of Blue Cross and Blue Shield of Oklahoma my true and lawful attorney to represent me at any and all meetings of the members of Blue Cross and Blue Shield of Oklahoma and to vote in my name upon any matters arising at said meetings. However, I retain the right to vote at any and all meetings of the members.

I have read all statements and notices on this application and represent that those items are true and complete to the best of my knowledge and belief. I know that any material misstatements or omissions of information that are made on this application may be the basis for later withdrawal of insurance coverage or denial of a loss incurred during my or my dependent's coverage. Any insurance agent, examining physician, or other person who knowingly or willfully makes a false or fraudulent statement or representation in or relative to an application for insurance, or who makes any such statement to obtain a fee, commission, money, or benefit shall be guilty of a misdemeanor according to TITLE 36, SECTION 1204 of the Oklahoma State Statutes.

I authorize my employer, as my agent, to deduct the amount of charges from my wages or salary for the purpose of paying my membership charges to the Plan.

I understand that if my application is being handled through a broker or agent, I authorize that broker or agent to receive and review my application, which may contain medical information about me or other family members listed on this application.

SIGNATURE OF APPLICANT (EMPLOYEE) - I AGREE TO ALL THE TERMS OF THIS APPLICATION

DATE SIGNED  
MO. DAY YR.

SIGNATURE OF SPOUSE - I AGREE TO ALL THE TERMS OF THIS APPLICATION

DATE SIGNED  
MO. DAY YR.