CHANGE FORM

If payment is enclosed, mail to:
For CompleteCare, PPOBlue or DirectBlue:
Highmark Blue Cross Blue Shield
P.O. Box 382089
Pittsburgh, PA 15230-0449

For KeystoneBlue:
Highmark Blue Cross Blue Shield
P.O. Box 382074
Pittsburgh, PA 15250-8051

If no payment is enclosed, mail to:
Highmark Blue Cross Blue Shield
Fifth Avenue Place
120 Fifth Avenue, Suite 2318
Pittsburgh, PA 15222-3099

How to complete this form:

1. Contract holder must complete Section 1. Please print. This information can be found on your I.D. card.
2. If you are requesting an address change only...complete Section 2 and Section 5. Then return this form to the appropriate address.
3. a. If you are requesting an enrollment change, such as a name, birthdate or a change in your deductible...complete Section 2 and Section 5. Then return this form to the appropriate address.
   b. If you are changing your program, you also need to fill out an application per the instructions noted below, including Sections 2 and 5.
4. a. If you are adding a newborn, an adopted child or a child being placed for adoption (within 31 days of the date of birth or the date of acquisition without medical underwriting, or within 90 days with medical underwriting and pre-existing condition limitations) to your agreement...complete Section 3 and Section 5. Then return this form to the appropriate address.
   b. If you are adding a dependent, including a spouse or child (other than a newborn, an adopted child or a child being placed for adoption) to your agreement, it must be done within 60 days from the date the dependent was acquired. Complete Section 3 and Section 5. **You also need to fill out an application,** including complete medical information only for the dependent you are adding. Then return this form to the appropriate address.
5. If you are deleting a spouse or dependent from your agreement...complete Section 4 and Section 5. Then return this form to the appropriate address.

SECTION 1 - CONTRACT HOLDER

LAST NAME	FIRST NAME	M. I.

SOCIAL SECURITY NUMBER	GROUP NUMBER

SECTION 2 - CHANGES (Provide information only for changes you are requesting)

TO ADD OR DELETE A MEMBER FROM YOUR PROGRAM, PLEASE SEE BACK OF THIS FORM.

❑ **ADDRESS CHANGE TO:**

❑ **NAME CHANGE OR CORRECTION TO:** (Last, First, Middle Initial. If due to marriage, please provide date of marriage)

❑ **BIRTHDATE CORRECTION TO:** (NAME: Last, First, Middle Initial) | **DATE OF BIRTH** (Month, Day, Year) / /

CURRENT PROGRAM AND DEDUCTIBLE

To change your current deductible to a new deductible, check below. All deductible levels can be **increased** only on the Contract Anniversary Date provided that the request is received one month prior to the Contract Anniversary Date. Deductible levels can be **decreased** as of the Contract Anniversary Date only after member holds a Contract for two consecutive years and the request is received at least one month prior to the Contract Anniversary Date.

❑ **CHANGE DEDUCTIBLE TO:**

❑ **INCREASE DIRECTBLUE DEDUCTIBLE TO:** ❑ **$500**
❑ **DECREASE DIRECTBLUE DEDUCTIBLE TO:** ❑ **$250**

❑ **INCREASE COMPLETECARE DEDUCTIBLE TO:** ❑ **$1,000**
❑ **DECREASE COMPLETECARE DEDUCTIBLE TO:** ❑ **$500**

❑ **INCREASE PPOBLUE DEDUCTIBLE TO:** ❑ **$2,600** ❑ **$3,500**
❑ **DECREASE PPOBLUE DEDUCTIBLE TO:** ❑ **$1,200** ❑ **$2,600**

To change from CompleteCare, KeystoneBlue or DirectBlue to PPOBlue, (1) select a PPOBlue deductible by checking the appropriate box below and (2) attach a copy of the PPOBlue program application. Fill out the General Information Section on page 1 and sign the Condition of Enrollment on page 7.

❑ **CHANGE PROGRAM TO PPOBLUE:**

❑ **PPOBLUE WITH $1,200 DEDUCTIBLE**
❑ **PPOBLUE WITH $2,600 DEDUCTIBLE**
❑ **PPOBLUE WITH $3,500 DEDUCTIBLE**

DO NOT WRITE BELOW THIS LINE

GROUP NUMBER	S/G	IDENTIFICATION NUMBER	TRANS EFFECTIVE DATE MONTH	DAY	YEAR
0					

COVERAGE CODE	PREVIOUS GROUP NUMBER	S/G	PREVIOUS IDENTIFICATION NUMBER
	0		

SECTION 3 - DEPENDENT ADDITION

❑ **NEWBORN**

❑ **Request received within 31 days of the date of birth:**
Newborns, adopted or placement for adoption dependents will be added to an existing agreement as of the 32nd day following birth, provided the request is received within 31 days of the date of birth. No medical underwriting is required. No pre-existing conditions will apply.

NAME: (Last, First, Middle Initial)	**DATE OF BIRTH** (Month, Day, Year)
	/ /

❑ **Request received within 32 to 90 days of the date of birth:**
Newborns, adopted or placement for adoption dependents will be added to an existing agreement as of the 32nd day following birth **subject to medical underwriting,** provided the request is received within 90 days of the date of birth. **Pre-existing conditions will apply. This form must be accompanied by an application,** including complete medical information only for the newborn you are requesting to add.

NAME: (Last, First, Middle Initial)	**DATE OF BIRTH** (Month, Day, Year)
	/ /

For the following additions, this form must be accompanied by an application. Include medical information only for the spouse and/or dependent(s) whom you are requesting to have added.

(Effective date of coverage for a spouse or dependent (other than a newborn, adopted or placement for adoption dependent) you are adding will be determined by the medical underwriting approval date. This form and an application must be received within 60 days from the date that the dependent was acquired.)

❑ **SPOUSE**

NAME: (Last, First, Middle Initial)	**DATE OF MARRIAGE** (Month, Day, Year)
	/ /

❑ **DEPENDENT**

NAME: (Last, First, Middle Initial)	**DATE OF ACQUISITION** (Month, Day, Year)
	/ /
NAME: (Last, First, Middle Initial)	**DATE OF ACQUISITION** (Month, Day, Year)
	/ /

If you are selecting KeystoneBlue coverage for your dependents, please choose a Primary Care Physician and complete the following:

Primary Care Physician's Name: ______________________________

Primary Care Physician's Number (obtain from PCP Directory): ______________________________

Primary Care Physician's status: ❑ Check here if presently a patient of this physician.

SECTION 4 - MEMBER DELETION

❑ **CONTRACT HOLDER** — **NAME:** (Last, First, Middle Initial)

❑ **SPOUSE** — **NAME:** (Last, First, Middle Initial)

❑ **DEPENDENT** — **NAME:** (Last, First, Middle Initial)

NAME: (Last, First, Middle Initial)

SECTION 5 - TO BE COMPLETED BY ALL APPLICANTS

I understand and agree that Highmark Blue Cross Blue Shield may void my subscription agreement within three years of the effective date if it is found that this subscription agreement was obtained or maintained by supplying materially incorrect or misleading enrollment eligibility information, except in the case of fraudulent statements or omissions, for which there is no time limit for voidance.

I hereby declare that all statements and answers as written or printed herein are full, complete, and true to the best of my knowledge and belief, and I agree that they are to be considered as a representation of the facts and not warranties.

APPLICANT'S SIGNATURE	**TODAY'S DATE**
SPOUSE'S SIGNATURE	**TODAY'S DATE**
HOME TELEPHONE NUMBER ( )	**WORK TELEPHONE NUMBER** ( )

NOTE: If a spouse is being added to an existing agreement, both spouses must complete and sign this change form and an application, and return both. If a living spouse is being deleted from an agreement, both spouses must sign this change form. If a dependent child is being added to an agreement, the contract holder must complete and sign this change form and an application, and return both. If a dependent child is being deleted from an agreement, the contract holder must sign this change form.

RETURN THIS APPLICATION BY: