



REQUEST FOR CHANGE FORM

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, is an independent licensee of the Blue Cross and Blue Shield Association.

PLEASE COMPLETE IN BLACK INK. PRINT USING CAPITAL LETTERS. THIS FORM MUST BE SIGNED ON PAGE 2 TO BE ACCEPTED.

MAIL TO: ENROLLMENT CONTROL CENTER P. O. BOX 1043 JACKSON, MS 39215-1043

INFORMATION TO BE COMPLETED BY EMPLOYER

Group Name

Group Name input field

Medical Group Number

Medical Group Number input field

Medical Contract Number\*

Medical Contract Number input field

\*Required if more than one medical benefit level

Dental Group Number\*

Dental Group Number input field

\*Required if employer has dental coverage

Dental Contract Number\*

Dental Contract Number input field

\*Required if more than one dental benefit level

Type of Change

- Form with checkboxes for Name, Address, Add Dependent(s), Drop Dependent(s), Group/Contract/Pay Loc, Cancel Medical Coverage, Cancel Dental Coverage, Cancel Life Coverage, Other

If Other, specify type of change.

If Other, specify type of change input field

Requested Effective Date of Change

Requested Effective Date of Change input field (mm-dd-yyyy)

If adding or dropping dependent, please check the appropriate reason for the change. Type of coverage (employee only, family, etc.) will be changed (if applicable) to reflect the dependents active on the policy.

- Form with checkboxes for Adoption/Custody\*, Guardianship\*, Open Enrollment, No Longer Student, Birth, Loss of Coverage, No Longer Dependent, Separation, Death, Marriage, Qualified Medical Child Support Order (QMCSO)\*, Divorce, Minor Child Over Age

Date of Change Reason Event

Date of Change Reason Event input field (mm-dd-yyyy)

\*NOTE: If adoption/custody, guardianship or QMCSO, attach copies of legal documents.

If canceling employee coverage, please specify reason for cancellation.

- Form with checkboxes for Left Full-Time Employment, Employee Request, Deceased

Date of Termination/Death

Date of Termination/Death input field (mm-dd-yyyy)

If changing group, contract, and/or pay location, please specify the applicable new information.

New Medical Group

New Medical Group input field

New Medical Contract

New Medical Contract input field

New Medical Pay Loc

New Medical Pay Loc input field

New Dental Group

New Dental Group input field

New Dental Contract

New Dental Contract input field

New Dental Pay Loc

New Dental Pay Loc input field

INFORMATION TO BE COMPLETED BY EMPLOYEE

Please complete the following information in full.

Employee Social Security Number/ID Number

Employee Social Security Number/ID Number input field

Employee Name (as it appears on ID Card)

First Name

First Name input field

M.I.

M.I. input field

Last Name

Last Name input field





**DEPENDENT INFORMATION - (Complete another Request for Change form if more than three dependents.)**

**Spouse**

DO NOT WRITE IN THIS SPACE  
BCBS UNDERWRITING USE ONLY:

Spouse  
Medical Waiver

Spouse  
Dental Waiver

If adding, dropping or changing spouse information, please complete the following information in full.

**Type of Change**

Add Dependent     Cancel Dependent Medical Coverage     Cancel Dependent Dental Coverage     Change Dependent Information

**Dependent First Name**

**M.I.**

**Last Name**

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**Social Security Number (if available)**

**Date of Birth**

**Sex**

						m	m	-	d	d	-	y	y	y	y	<input type="checkbox"/> Male <input type="checkbox"/> Female	
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**SPOUSE:** If adding spouse, please complete the following information in full. If changing spouse information, complete only the information to be changed. This section does not need to be completed if dropping spouse coverage.

**Has dependent had prior insurance coverage within the past 18 months?**

If yes and other coverage was with BCBS of Mississippi, please specify ID number for the coverage.

<input type="checkbox"/> Yes <input type="checkbox"/> No		(NOTE: If prior coverage was not with BCBS of Mississippi, creditable coverage form must be attached.)											
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Does spouse have other health coverage that will also be in effect at the same time as the current Blue Cross & Blue Shield of Mississippi coverage?

Yes     No

**If other coverage will be in effect, please complete the following other insurance information:**

<b>Other Insurance Policyholder Name</b>																			
<b>Policyholder Date of Birth</b>										<b>Type of Other Insurance Coverage</b>									
m m - d d - y y y y										<input type="checkbox"/> Covered With Employer <input type="checkbox"/> Not Covered With Employer									
<b>Other Insurance Effective Date</b>										<b>Policyholder Employment Status (If Covered With Employer)</b>									
m m - d d - y y y y										<input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA									
<b>Other Insurance Policy Number</b>																			
<b>Other Insurance Carrier Name</b>																			

**Medicare Information**

Does your spouse have Medicare coverage?

If yes, specify the type(s) of Medicare coverage in effect.

<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Part A <input type="checkbox"/> Part B	
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If Medicare coverage is in effect, please complete the following information:

<b>Medicare Number</b>										<b>Reason for Entitlement</b>																			
										<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End-Stage Renal Disease (ESRD)																			
<b>Part A Effective Date (if applicable)</b>										<b>Part B Effective Date (if applicable)</b>										<b>Date of Entitlement</b>									
m m - d d - y y y y										m m - d d - y y y y										m m - d d - y y y y									



**Child (1)**

DO NOT WRITE IN THIS SPACE  
BCBS UNDERWRITING USE ONLY:

Child (1)  
Medical Waiver

Child (1)  
Dental Waiver

If adding, dropping or changing child information, please complete the following information in full.

**Type of Change**

- Add Dependent
- Cancel Dependent Medical Coverage
- Cancel Dependent Dental Coverage
- Change Dependent Information

**Dependent First Name**

**M.I.**

**Last Name**

**Social Security Number (if available)**

**Date of Birth**

**Sex**

- Male
- Female

**CHILD (1):** If adding child, please complete the following information in full. If changing child information, complete only the information to be changed. This section does not need to be completed if dropping child coverage.

**Full-Time Student?**

- Yes
- No

If full-time student, please list accredited college or university name.

**Has dependent had prior insurance coverage within the past 18 months?**

- Yes
- No

(NOTE: If prior coverage was not with BCBS of Mississippi, creditable coverage form must be attached.)

If yes and other coverage was with BCBS of Mississippi, please specify ID number for the coverage.

Does child have other health coverage that will also be in effect at the same time as the current Blue Cross & Blue Shield of Mississippi coverage?

- Yes
- No

**If other coverage will be in effect, please complete the following other insurance information:**

**Other Insurance Policyholder Name**

**Policyholder Date of Birth**

**Type of Other Insurance Coverage**

- Covered With Employer
- Not Covered With Employer

**Other Insurance Effective Date**

**Policyholder Employment Status (If Covered With Employer)**

- Active Employee
- Retiree
- COBRA

**Other Insurance Policy Number**

**Other Insurance Carrier Name**

Does other insurance policyholder have medical responsibility or custody for this dependent due to divorce?

- Yes
- No

**Is dependent disabled?**

- Yes
- No

**Is dependent a COBRA participant?**

- Yes
- No

**Medicare Information**

**Does dependent have Medicare coverage?**

- Yes
- No

**If yes, specify the type(s) of Medicare coverage in effect.**

- Part A
- Part B

**If Medicare coverage is in effect, please complete the following information:**

**Medicare Number**

**Reason for Entitlement**

- Age
- Disability
- End-Stage Renal Disease (ESRD)

**Part A Effective Date (if applicable)**

**Part B Effective Date (if applicable)**

**Date of Entitlement**



**Child (2)**

DO NOT WRITE IN THIS SPACE  
BCBS UNDERWRITING USE ONLY:

Child (2)  
Medical Waiver

Child (2)  
Dental Waiver

If adding, dropping or changing child information, please complete the following information in full.

**Type of Change**

- Add Dependent
- Cancel Dependent Medical Coverage
- Cancel Dependent Dental Coverage
- Change Dependent Information

**Dependent First Name**

**M.I.**

**Last Name**

**Social Security Number (if available)**

**Date of Birth**

**Sex**

- Male
- Female

**CHILD (2):** If adding child, please complete the following information in full. If changing child information, complete only the information to be changed. This section does not need to be completed if dropping child coverage.

**Full-Time Student?**

- Yes
- No

If full-time student, please list accredited college or university name.

**Has dependent had prior insurance coverage within the past 18 months?**

- Yes
- No

(NOTE: If prior coverage was not with BCBS of Mississippi, creditable coverage form must be attached.)

If yes and other coverage was with BCBS of Mississippi, please specify ID number for the coverage.

Does child have other health coverage that will also be in effect at the same time as the current Blue Cross & Blue Shield of Mississippi coverage?

- Yes
- No

**If other coverage will be in effect, please complete the following other insurance information:**

**Other Insurance Policyholder Name**

**Policyholder Date of Birth**

**Type of Other Insurance Coverage**

- Covered With Employer
- Not Covered With Employer

**Other Insurance Effective Date**

**Policyholder Employment Status (If Covered With Employer)**

- Active Employee
- Retiree
- COBRA

**Other Insurance Policy Number**

**Other Insurance Carrier Name**

Does other insurance policyholder have medical responsibility or custody for this dependent due to divorce?

- Yes
- No

**Is dependent disabled?**

- Yes
- No

**Is dependent a COBRA participant?**

- Yes
- No

**Medicare Information**

**Does dependent have Medicare coverage?**

- Yes
- No

**If yes, specify the type(s) of Medicare coverage in effect.**

- Part A
- Part B

**If Medicare coverage is in effect, please complete the following information:**

**Medicare Number**

**Reason for Entitlement**

- Age
- Disability
- End-Stage Renal Disease (ESRD)

**Part A Effective Date (if applicable)**

**Part B Effective Date (if applicable)**

**Date of Entitlement**



**Child (3)**

DO NOT WRITE IN THIS SPACE  
BCBS UNDERWRITING USE ONLY:

Child (3)  
Medical Waiver

Child (3)  
Dental Waiver

If adding, dropping or changing child information, please complete the following information in full.

**Type of Change**

- Add Dependent
- Cancel Dependent Medical Coverage
- Cancel Dependent Dental Coverage
- Change Dependent Information

**Dependent First Name**

**M.I.**

**Last Name**

**Social Security Number (if available)**

**Date of Birth**

**Sex**

- Male
- Female

**CHILD (3):** If adding child, please complete the following information in full. If changing child information, complete only the information to be changed. This section does not need to be completed if dropping child coverage.

**Full-Time Student?**

- Yes
- No

If full-time student, please list accredited college or university name.

**Has dependent had prior insurance coverage within the past 18 months?**

- Yes
- No

(NOTE: If prior coverage was not with BCBS of Mississippi, creditable coverage form must be attached.)

If yes and other coverage was with BCBS of Mississippi, please specify ID number for the coverage.

Does child have other health coverage that will also be in effect at the same time as the current Blue Cross & Blue Shield of Mississippi coverage?

- Yes
- No

**If other coverage will be in effect, please complete the following other insurance information:**

**Other Insurance Policyholder Name**

**Policyholder Date of Birth**

**Type of Other Insurance Coverage**

- Covered With Employer
- Not Covered With Employer

**Other Insurance Effective Date**

**Policyholder Employment Status (If Covered With Employer)**

- Active Employee
- Retiree
- COBRA

**Other Insurance Policy Number**

**Other Insurance Carrier Name**

Does other insurance policyholder have medical responsibility or custody for this dependent due to divorce?

- Yes
- No

**Is dependent disabled?**

- Yes
- No

**Is dependent a COBRA participant?**

- Yes
- No

**Medicare Information**

**Does dependent have Medicare coverage?**

- Yes
- No

**If yes, specify the type(s) of Medicare coverage in effect.**

- Part A
- Part B

**If Medicare coverage is in effect, please complete the following information:**

**Medicare Number**

**Reason for Entitlement**

- Age
- Disability
- End-Stage Renal Disease (ESRD)

**Part A Effective Date (if applicable)**

**Part B Effective Date (if applicable)**

**Date of Entitlement**

