

Regence BlueCross BlueShield of Utah, Regence HealthWise and Regence ValueCare are Independent Licensees of the Blue Cross and Blue Shield Association

SUBSCRIBER INFO	<p>(PLEASE PRINT)</p> <p>_____ (Last Name) _____ (First Name) _____ (Initial)</p> <p>Subscriber Identification Number: _____</p> <p>Current Group Number: _____</p>	<p style="text-align: center;">INSTRUCTIONS</p> <p>For name, address, family status and/or life beneficiary changes, please complete the appropriate section(s) below. All other changes should be reported on the "Application for Membership" form. Leave all shaded areas blank for the use of Regence BlueCross BlueShield of Utah. Failure to complete all applicable information may result in a delay in processing your membership.</p>
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ADDRESS CHANGE	<p>New Mailing Address or P.O. Box if applicable _____ (Street) _____ (Apt.)</p> <p>_____ (City) _____ (State) _____ (Zip)</p>
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NAME CHANGE	<p>From: _____ To: _____</p> <p>If reason for change is marriage, list Date of Marriage _____ / _____ / _____ and check appropriate space below:</p> <p><input type="checkbox"/> I wish to add my spouse to my coverage and have accordingly listed his/her name in the "Additional Family Members" section.</p> <p><input type="checkbox"/> I do not wish to add my spouse to my coverage</p>
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Effective Date	Membership Status	Adult Code	Family Members	Special Code	Medically Underwritten
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Please complete the "Application for Pre-Existing Condition Credit" if you are adding a family member and if you are employed by a company with fewer than 51 employees who are eligible for health insurance.

ADDITIONAL FAMILY MEMBERS						Must Be Completed for Each Member Covered by Other Insurance (including Medicare)				
	Relationship to Subscriber	Full Name(s) of Member(s) to be Covered	Birthdate Mo/Day/Yr	Social Security Number For Each Dependent	Primary Care Physician Selected (for Regence HealthWise, HMOBlue and Point of Service only)	PCP Code	Carrier Name	Medical	Dental	Drug
			/ /							
			/ /							
			/ /							
			/ /							

DELETION OF MEMBERS	Relationship to Subscriber	Full Name(s) of Member(s) to be Deleted	For Each Change – List:	
			Reason	Effective Date
	Spouse <input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			

LIFE CHANGES	Beneficiary's Name _____ Relationship _____ <small>(Last Name) (First Name) (Initial)</small>
	Contingent Beneficiary _____ Relationship _____ <small>(Last Name) (First Name) (Initial)</small>
	Supplemental Group Life (if applicable): Amount _____
	Life Carrier _____ Life Amount _____ Short Term Disability: <input type="checkbox"/> Yes <input type="checkbox"/> No Class _____ Dependent Life: <input type="checkbox"/> Yes <input type="checkbox"/> No Long Term Disability: <input type="checkbox"/> Yes <input type="checkbox"/> No

PRE-EXISTING CONDITIONS	Any coverage issued in connection with the addition of any family member through submission of this Change Form E-27 may contain a limitation on the coverage of pre-existing conditions. If the added family member has prior creditable coverage, it may be available to reduce the period of the pre-existing condition limitation. We will assist the added family member in obtaining a certificate of creditable coverage, if necessary.
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SIGNATURE	<p>I, the undersigned, hereby request Regence BlueCross BlueShield of Utah, Regence HealthWise and/or Regence ValueCare, hereinafter known as "the Plan," to change my membership in the Plan as noted hereon, subject to prevailing rules, regulations and premiums of the Plan and in accordance with my present contract with the Plan. I understand any change in family status may affect my monthly premiums.</p> <p>Any matter in dispute between you and the Plan may be subject to arbitration as an alternative to court action pursuant to the rules of, the American Arbitration Association or other recognized arbitrator, a copy of which is available on request from the Plan. The Plan shall bear the costs of arbitration, filing fees, administrative fees and arbitrator fees. Other expenses of arbitration, including, but not limited to: attorney fees, expenses of discovery, witnesses, stenographer, translators, and similar expenses, will be borne by the party incurring those expenses. Any decision reached by arbitration shall be binding upon both you and the Plan. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.</p>
	<p>_____ Subscriber Signature</p> <p>_____ Date Signed</p>

THIS FORM MUST BE SIGNED AND DATED