

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

<b>SUBSCRIBER INFO</b>	<b>(PLEASE PRINT)</b>			<b>INSTRUCTIONS</b>  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 Enrollment/Waiver" 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.
	(Last Name) _____	(First Name) _____	(Initial) _____	
	Subscriber Identification Number: _____			
	Current Employer Group Name: _____			
Current Employer Group Number: _____				

<b>ADDRESS CHANGE</b>	New Mailing Address or P.O. Box if applicable _____		
	(Street)		(Apt.)
	(City)	(State)	(Zip)

<b>NAME CHANGE</b>	From: _____ To: _____	
	If reason for change is marriage, list <b>Date of Marriage</b> _____ / _____ / _____ and check appropriate space below:	
	<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. <input type="checkbox"/> I do not wish to add my spouse to my coverage	

Effective Date	Membership Status	Adult Code	Family Members	Special Code	Medically Underwritten
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Please complete the "Prior Coverage Information" form 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.

<b>ADDITIONAL FAMILY MEMBERS</b>	Relationship to Subscriber	Full Name(s) of Member(s) to be Covered	Birthdate Mo/Day/Yr	Height Ft -- In	Weight Lbs.	Social Security Number For Each Dependent	Must Be Completed for Each Member Covered by Other Insurance (including Medicare)			
							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
	Subscriber <input type="checkbox"/> M <input type="checkbox"/> F			
	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	<p>If your life or disability insurance is administered by Regence Life and Health Insurance Company and you wish to make changes, please contact your Plan Administrator for further instructions.</p> <p>If your life or disability insurance is administered by Highmark Life and Casualty (TransGeneral Life) and you wish to make changes, please provide the information below.</p>		
	Beneficiary's Name _____	Relationship _____	
	(Last Name)                      (First Name)                      (Initial)		
	Contingent Beneficiary _____	Relationship _____	
	(Last Name)                      (First Name)                      (Initial)		
	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	<p>Any coverage issued in connection with the addition of any family member through submission of this <b>Change Form E-27</b> 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.</p>
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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