

INSTRUCTIONS TO COMPLETE THE CHANGE FORM

- Line 1** Fill in your member ID number or social security number and name. If you need a new ID card, check the "please send ID card" box.
- Line 2** If your address has changed, fill in your correct address.
- Line 3** If your name has changed, fill in your correct name and check the reason for your name change. Fill in your home phone number.
- Line 4** Fill in your correct date of birth and marital status. If you wish to cancel coverage, check the "I wish to cancel coverage" box.
- Line 5** If you desire to change your coverage, select the coverage you are choosing. If your spouse is an active or retired teacher or State employee, give your spouse's name and member ID number.
- Line 6** If you are removing or adding dependents, check "remove" or "add". Check the event that occurred that allows the change and provide the date of the event.
- Line 7** If you are removing dependents and the dependent's address is different from yours, fill in the dependent's address.
- Lines 8 through 11** If you are removing dependents, check "remove" and list the dependent's name(s) to be removed.
- If you are adding your spouse, check "add" on line 8 and provide his/her first name, middle initial, last name and social security number. Enter his/her date of birth and gender. Check "yes" or "no" to indicate whether he/she has Medicare. If "yes" is checked, complete line 13 or 14.
- If you are adding a child or children, check "add" on line 9 through 11, as applicable, and provide each eligible dependent child's name, middle initial, last name and social security number. Enter your child's date of birth, gender and relationship to you. Complete a Certification of Dependent Eligibility form for each foster child (available from your Health Benefits Representative or from www.shpnc.org) and attach it to this form.
- If you have a child over 26 who is mentally or physically incapacitated, check "handicapped" and complete a Coverage Request for Mentally or Physically Incapacitated Children (available from your Health Benefits Representative or from www.shpnc.org) and attach it to this form.
- Check "yes" or "no" to indicate whether your child is eligible for Medicare. If "yes" is checked, complete line 13 or 14.
- Your Health Benefits Representative will complete the waiting period information.
- Line 12** Read this statement and sign if you have listed dependent children to be enrolled on lines 9 through 11. Dependent children must not be eligible for their own or their spouse's employer-sponsored health coverage.
- Line 13 and 14** If you, your spouse, or any of your children to be enrolled are eligible for Medicare, give the name, Medicare claim number, reason for Medicare eligibility, and the dates enrolled in Part A and Part B. Complete the Prior Coverage/Other Coverage Information form (available from your Health Benefits Representative or from www.shpnc.org) if you or your dependents have other group health coverage in addition to the State Health Plan that will remain in effect after the effective date of this form, or if you or your dependents over 19 had other coverage that ended within the past 63 days. Attach it to this form.
- Line 15**
- Employee Authorization** Read this statement, sign and date the form. Return the form to your Health Benefits Representative. If you have questions about this form, contact your Health Benefits Representative or State Customer Service at **1-888-234-2416**.
- Your Health Benefits Representative will complete the remaining information.

Blue Cross and Blue Shield of North Carolina, the North Carolina State Health Plan and North Carolina HealthSmart are not affiliated. Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

CHANGE FORM

PLEASE TYPE OR PRINT CLEARLY IN BLUE OR BLACK INK. DO NOT WRITE IN SHADED AREAS.

1. SUBSCRIBER/MEMBER ID NO.	SOCIAL SECURITY NUMBER	LAST NAME	FIRST	INITIAL	PLEASE SEND ID CARD <input type="checkbox"/>
2. CHANGE MY ADDRESS TO		STREET - ROUTE NO./BOX NO.		CITY	STATE ZIP
3. CHANGE MY NAME TO		LAST NAME	FIRST	INITIAL	BECAUSE OF <input type="checkbox"/> MARRIAGE <input type="checkbox"/> LEGAL CHANGE
4. CORRECT MY BIRTHDATE TO		MO.	BIRTHDATE DATE	YEAR	CHANGE MY MARITAL STATUS TO
5. CHANGE MY COVERAGE TO		<input type="checkbox"/> EMPLOYEE ONLY	<input type="checkbox"/> EMPLOYEE-CHILD/REN	<input type="checkbox"/> EMPLOYEE-SPOUSE	<input type="checkbox"/> EMPLOYEE-FAMILY
6. REMOVE, CHANGE OR ADD DEPENDENTS		REASON AND DATE OF EVENT REQUIRED		COMPLETE IF YOUR SPOUSE IS A TEACHER OR STATE EMPLOYEE	
<input type="checkbox"/> REMOVE MY <input type="checkbox"/> SPOUSE <input type="checkbox"/> ADD MY <input type="checkbox"/> DEPENDENT CHILD/REN		<input type="checkbox"/> MARRIAGE ___/___/___ <input type="checkbox"/> SEPARATION ___/___/___ <input type="checkbox"/> DIVORCE ___/___/___		<input type="checkbox"/> DEATH ___/___/___ <input type="checkbox"/> NEWBORN ___/___/___ <input type="checkbox"/> STEPCHILD ___/___/___ <input type="checkbox"/> FOSTER CHILD ___/___/___	
7. REMOVE DEPENDENTS		ADDRESS (IF DIFFERENT FROM YOURS)		STREET - ROUTE NO./BOX NO.	CITY STATE ZIP COUNTY

DEPENDENT INFORMATION → List dependents to be added or removed. List additional children to be added on a separate form.

	NAME <i>(First, Middle Initial, Last)</i>	SOCIAL SECURITY NUMBER	BIRTHDATE	GENDER	CHILD IS MY	CHECK IF APPLICABLE	MEDICARE ELIGIBLE?	DOES WAITING PERIOD APPLY?
8. <input type="checkbox"/> REMOVE <input type="checkbox"/> ADD	SPOUSE	REQUIRED	MONTH DAY YEAR ___/___/___	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			<input type="checkbox"/> YES <input type="checkbox"/> NO <small>(see lines 13 & 14)</small>	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. <input type="checkbox"/> REMOVE <input type="checkbox"/> ADD	CHILD 1		MONTH DAY YEAR ___/___/___	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> NATURAL <input type="checkbox"/> FOSTER <input type="checkbox"/> ADOPTED <input type="checkbox"/> STEP	<input type="checkbox"/> HANDICAPPED	<input type="checkbox"/> YES <input type="checkbox"/> NO <small>(see lines 13 & 14)</small>	<input type="checkbox"/> YES <input type="checkbox"/> NO
10. <input type="checkbox"/> REMOVE <input type="checkbox"/> ADD	CHILD 2		MONTH DAY YEAR ___/___/___	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> NATURAL <input type="checkbox"/> FOSTER <input type="checkbox"/> ADOPTED <input type="checkbox"/> STEP	<input type="checkbox"/> HANDICAPPED	<input type="checkbox"/> YES <input type="checkbox"/> NO <small>(see lines 13 & 14)</small>	<input type="checkbox"/> YES <input type="checkbox"/> NO
11. <input type="checkbox"/> REMOVE <input type="checkbox"/> ADD	CHILD 3		MONTH DAY YEAR ___/___/___	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> NATURAL <input type="checkbox"/> FOSTER <input type="checkbox"/> ADOPTED <input type="checkbox"/> STEP	<input type="checkbox"/> HANDICAPPED	<input type="checkbox"/> YES <input type="checkbox"/> NO <small>(see lines 13 & 14)</small>	<input type="checkbox"/> YES <input type="checkbox"/> NO

12. I ATTEST THAT MY DEPENDENT CHILD(REN) IS NOT ELIGIBLE FOR THEIR OWN OR THEIR SPOUSE'S EMPLOYER-SPONSORED HEALTH COVERAGE.
SIGNATURE: _____

MEDICARE INFORMATION List below yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

NAME	MEDICARE CLAIM NUMBER	ENTITLED DUE TO	EFFECTIVE DATE ENROLLED
13.		<input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> RENAL DISEASE	PART A (MM/DD/YY): ___/___/___ PART B (MM/DD/YY): ___/___/___
14.		<input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> RENAL DISEASE	PART A (MM/DD/YY): ___/___/___ PART B (MM/DD/YY): ___/___/___

15. **OTHER GROUP HEALTH COVERAGE** COMPLETE THE PRIOR COVERAGE/OTHER COVERAGE INFORMATION FORM IF YOU OR YOUR DEPENDENTS HAVE OTHER GROUP HEALTH COVERAGE IN ADDITION TO THE STATE HEALTH PLAN THAT WILL REMAIN IN EFFECT AFTER THE EFFECTIVE DATE OF THIS FORM, OR IF YOU OR YOUR DEPENDENTS OVER 19 HAD OTHER COVERAGE THAT ENDED WITHIN THE PAST 63 DAYS.

16. COMMENTS _____

EMPLOYEE AUTHORIZATION

I hereby apply for the changes, adjustments and/or additions to my enrollment listed on the form above and I agree that all information provided is correct. I further agree that we shall abide by the provisions of the Agreement for the selected plan option.

I hereby authorize my employer to deduct from my earnings any deduction for the coverage elected above.

DESIRED EFFECTIVE DATE OF CHANGE _____ **01** _____
MONTH DAY YEAR

EMPLOYEE'S SIGNATURE _____ DATE SIGNED _____

EMPLOYING UNIT MUST COMPLETE

EMPLOYING UNIT NAME	
GROUP NO.	HIRE DATE
PAYROLL NO.	DEPARTMENT NO.
DOES MEDICARE REDUCED RATE APPLY? <input type="checkbox"/> NO <input type="checkbox"/> YES	
EMPLOYEE DEDUCTION \$	EFFECTIVE DATE
EMPLOYER CONTRIBUTION \$	01