



CHANGE FORM

If payment is enclosed, mail to:
 Highmark Blue Shield
 P.O. Box 382051
 Pittsburgh, PA 15250-8051

If no payment is enclosed, mail to:
 Highmark 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.		
<input type="checkbox"/> ADDRESS CHANGE TO:		
<input type="checkbox"/> NAME CHANGE OR CORRECTION TO: (Last, First, Middle Initial. If due to marriage, please provide date of marriage)		
<input type="checkbox"/> BIRTHDATE CORRECTION TO: (NAME: Last, First, Middle Initial)		DATE OF BIRTH (Month, Day, Year) / /
CURRENT PROGRAM AND DEDUCTIBLE		
<p>To change your current deductible to a new deductible, check below. For DirectBlue, the deductible level can be increased from \$0 to \$250 or \$500 on the first of any month provided that the request is received one month prior to the requested date. All other 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 level 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.</p>		
<input type="checkbox"/> CHANGE DEDUCTIBLE TO:		
<input type="checkbox"/> INCREASE DIRECTBLUE DEDUCTIBLE TO: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> DECREASE DIRECTBLUE DEDUCTIBLE TO: <input type="checkbox"/> \$0 <input type="checkbox"/> \$250 <input type="checkbox"/> INCREASE PPOBLUE DEDUCTIBLE TO: <input type="checkbox"/> \$2,600 <input type="checkbox"/> \$3,500 <input type="checkbox"/> DECREASE PPOBLUE DEDUCTIBLE TO: <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$2,600		
<p>To change from 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.</p>		
<input type="checkbox"/> CHANGE PROGRAM TO PPOBLUE:		
<input type="checkbox"/> PPOBLUE WITH \$1,200 DEDUCTIBLE <input type="checkbox"/> PPOBLUE WITH \$2,600 DEDUCTIBLE <input type="checkbox"/> PPOBLUE WITH \$3,500 DEDUCTIBLE		

DO NOT WRITE BELOW THIS LINE						
GROUP NUMBER	S/G	IDENTIFICATION NUMBER			TRANS EFFECTIVE DATE	
0					MONTH	DAY
					YEAR	
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) / /
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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) / /
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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) / /
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DEPENDENT

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

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