



# Blue Cross Blue Shield of Mississippi

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

# Change Form

PLEASE PRINT ALL INFORMATION

## To Be Completed By Human Resources

Group Number	Employee Type: <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retired			
Enrollment: <input type="checkbox"/> Open <input type="checkbox"/> Qualifying Event	(check event and give event date)	<input type="checkbox"/> Group Transfer	<input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Deceased	Event Date:
Employee Occupation:				

## EMPLOYEE TO COMPLETE IN FULL

Employee Social Security Number / ID Number	Employee First Name	M.I.	Last Name	Phone Number
Type of Coverage: <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Coverage <input type="checkbox"/> Drop Dependent <input type="checkbox"/> Add Dependent <input type="checkbox"/> Other, Specify:				Requested Effective Date of Change

## EMPLOYEE TO COMPLETE ONLY ITEMS TO BE CHANGED

Employee Address Change: Mailing / Street Address	Apt / Suite	City	State	Zip Code
Coverage Changes:	From	To	Type Coverage	If adding or dropping dependents, give reason. List below dependents to be added or terminated.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Employee Only	<input type="checkbox"/> Adoption <input type="checkbox"/> Divorce <input type="checkbox"/> Minor Child Over Age
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Employee + Children	<input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> No Longer Dependent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family	<input type="checkbox"/> Court Order <input type="checkbox"/> MDHS <input type="checkbox"/> No Longer Student
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Employee + Spouse	<input type="checkbox"/> Custody/Guardianship <input type="checkbox"/> Employee Requested Term
				Date Of Event
				<input type="text"/> - <input type="text"/> - <input type="text"/>
NOTE: If adoption, custody, guardianship, court order, MDHS or divorce attach copies of legal documents.				

Indicate for each individual "C" if change, "A" if addition or "T" if termination.

NAME AND OTHER CHANGES	FULL NAME	FIRST NAME	SOCIAL SECURITY NUMBER (Required)	RELATIONSHIP TO EMPLOYEE	SEX M/F	DATE OF BIRTH			INDICATE YES OR NO FOR EACH ITEM BELOW				
		LAST NAME				MO	DAY	YEAR	FULL-TIME STUDENT IF AGE 19 - 25	COBRA PARTICIPANT	OTHER HEALTH COVERAGE IF YES, COMPLETE "OTHER COVERAGE" FORM.	CREDITABLE COVERAGE IF YES, PROVIDE FROM AND THROUGH DATES.	
												FROM	THROUGH
	Husband/Wife												
	Children												

Name of school for those age 19 and over \_\_\_\_\_

I hereby apply for change of my membership agreement as indicated on this application. I understand and agree that this Change Form will become part of my original Enrollment Form (Application), and will be subject to the terms and conditions of my Employer's enrollment regulations. I warrant that all statements made herein are complete and true. I certify that the person(s) listed hereon are my Dependents and that I will notify my Employer of any change of Dependent status.

EMPLOYEE SIGNATURE	DATE
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