BlueCross BlueShield 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: ☐ Active ☐ COBRA ☐ Retired

Enrollment: ☐ Open ☐ Qualifying Event (check event and give event date) ☐ Group Transfer ☐ Loss of Coverage ☐ 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:
☐ Name ☐ Address ☐ Coverage ☐ Drop Dependent ☐ Add Dependent ☐ 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
☐	☐	Employee Only
☐	☐	Employee + Children
☐	☐	Family
☐	☐	Employee + Spouse

If adding or dropping dependents, give reason. List below dependents to be added or terminated.

☐ Adoption ☐ Divorce ☐ Minor Child Over Age
☐ Birth ☐ Marriage ☐ No Longer Dependent
☐ Court Order ☐ MDHS ☐ No Longer Student
☐ Custody/Guardianship ☐ Employee Requested Term

Date Of Event
☐☐ - ☐☐ - ☐☐☐☐

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 / LAST NAME	SOCIAL SECURITY NUMBER (Required)	RELATIONSHIP TO EMPLOYEE	SEX M/F	DATE OF BIRTH MO	DAY	YEAR	INDICATE YES OR NO FOR EACH ITEM BELOW: 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