



AGENT
Change of Status Request Form
For Individual Billed Member

SUBSCRIBER NAME	GROUP NUMBER	CONTRACT NUMBER (Required)

MEMBER CHANGES

Add the following person(s) to my contract:
Reason: Marriage* to (must be notified within 30 days of event*) Birth* of Other: _____

Remove the following person(s) from my contract:
Reason: Death Divorce Enrolled in Medicare Plus Blue (ID# _____) Effective Date: _____ Other: _____

Last Name	First Name	M.I.	Sex	Date of Birth MM/DD/YYYY	Social Security Number	Date of Event	*Rel. Code
Spouse							
Dependent							
Dependent							

***Relationship Codes:**
N – Biological/Adopted Child **P** – Principal Support (Attach Court Document) **C** – Court Order Coverage (QMSCO) (Attach Court Order)
S – Stepchild **A** – Child Adoption in Progress (Attach Court Document) **D** – Disabled Child (PA275) (Attach Physician Statement)
L – Legal Guardianship (Attach Court Document)

COVERAGE CHANGES

Change my health care plan to: **(Benefit changes are allowed only at contract anniversary date.)**
Note: Group Conversion is not available for Individual Care Blue Plus, Flex Blue II 1500 or Keep Fit

Young Adult Blue Max Call the Agent Hotline at 1-800-788-7334 to change to Young Adult Blue Max, EFT and e-mail address is required.

PPO plans: **Individual Care Blue Plus** **Flexible Blue II- 2500** **Keep Fit**
 optional Flexible Blue Dental Plus optional Flexible Blue Dental Plus 1500 7500
 Flexible Blue II- 1500 optional maternity 2500 10,000
 optional maternity **Flexible Blue II- 5000** 5000
 optional Flexible Blue Dental Plus optional Flexible Blue Dental Plus

Dental Plans: **Personal Blue Dental** **Personal Blue Dental Plus**
Personal Blue Dental and Personal Blue Dental Plus are only available for Young Adult Blue Max, Keep Fit and Closed Products

EFFECTIVE DATE CHANGES

Choose from the following date: 1st or 15th
 Change my future effective date to: ____/____/____ (MM/DD/CCYY)
(non-group only) (only within 30 days of effective date)

OTHER CHANGES

Name Change: Last Name First Name Middle Initial

Address Change:

Address	City	State	Zip Code
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Telephone Number Change: ()

Terminate Contact effective next cycle date following the receipt of this request.
Note: you will not be allowed to enroll in any BCBSM individual market product for 6 months after your termination date.

SUBSCRIBER'S SIGNATURE
(Required for Contract Termination ONLY)

DATE

Please contact the Agent Hotline at 1-800-788-7334 for questions.

Agent code	MA/GA code	Assn./Chamber code	Managing Agent/General Agent/Agent Signature

E-mail all Change of Status request to: IBUAgentMembershipRequests@bcbsm.com OR Fax to: 866-392-7528.