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	RELATIONSHIP TO EMPLOYEE	SEX M/F	DATE OF BIRTH 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