



Plan Change Request Form

BenefIts Medical Coverage



Use this form to simplify employee and dependent plan change requests during your group's open window. Approved changes will become effective on the first of the month following receipt of all approved documents.

1) Please tell us who you are and how we can reach you:

Company Name		Contact Name	
Blue Cross Group No.	Phone	E-mail	FAX

2) Provide the following information for members who want to move to another BenefIts plan. Please note that the Hospital BenefIts Preferred Plan includes dental and vision coverage; members cannot be enrolled in this plan at the same time they are also enrolled in any stand-alone Blue Cross dental or vision plans offered by the employer.

Member's Name	Member's Social Security or ID No.	MEMBER WISHES TO BE MOVED TO THE PLAN SELECTED (CHECK ONE)						If Power Select HMO checked, provide Primary Care Physician number here.
		X350 Hospital BenefIts	X351 Hospital BenefIts Plus	X352 Hospital BenefIts Preferred	X355 PPO \$35 Copay GenRx	Y370 Power Select HMO		
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Please photocopy form if additional rows are needed

3) Complete owner/officer certification:

I am an owner or officer of this company, and hereby authorize these changes to our Blue Cross group medical coverage.
 Signature _____ Printed Name _____ Date _____

4) Submit: FAX TO 805-480-7024 (a cover sheet is not needed) or mail to **PO BOX 9042, Oxnard, CA, 93031**.
 You may be contacted by a Blue Cross representative if there are any questions about this request.