

Plans for Individuals and Families

Medical Plan Option Change Form

EXISTING MEMBERS MAY USE THIS FORM TO REQUEST A MEDICAL PLAN CHANGE

Please be sure to complete ALL information below to avoid delays in processing.

If you have any questions, please call us at (401) 459-5000 or 1-800-639-2227.

Please print clearly using blue or black ink or type in information.

Section 1 Applicant Information

Last name _____ M.I. _____ First name _____ Suffix _____

Home address _____ City/town _____ State _____ ZIP code _____

Mailing address _____

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Gender M F Social security number¹ _____ - _____ - _____

Current BCBSRI ID _____ Home phone number _____ Cell phone number _____

What is your primary language spoken? _____ E-mail address _____

Race (please check one)

- American Indian or Alaska Native Asian Black or African American Hispanic or Latino
 Multiracial Native Hawaiian or other Pacific Islander White

continued ►

¹Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html

Section 2 Medical Plan Options

I understand the options available and I hereby request the following coverage changes for myself and my dependents (if applicable):

Choose a Medical Plan Option (please check one):

Choose a **medical** contract type: Individual Family

Requested medical effective date (mm/dd/yyyy): ___ / ___ / ____

<p>VantageBlue Direct</p> <input type="checkbox"/> \$1,000/2,000 Gold <input type="checkbox"/> \$3,000/6,000 Silver	<p>VantageBlue Direct with Dental</p> <input type="checkbox"/> \$1,200/2,400 Gold	<p>BlueSolutions for HSA Direct</p> <input type="checkbox"/> \$1,400/2,800 Gold <input type="checkbox"/> \$3,900/7,800 Silver <input type="checkbox"/> \$3,700/7,400 Bronze <input type="checkbox"/> \$5,350/10,700 Bronze	<p>BasicBlue Direct</p> <input type="checkbox"/> \$2,750/5,500 Gold <input type="checkbox"/> \$4,900/9,800 Silver <input type="checkbox"/> \$6,850/13,700 Bronze
<p>BlueCHIP Direct</p> <input type="checkbox"/> \$4,500/9,000 Silver			
<p>You are required to select a primary care physician for yourself and dependents (if applicable) for this plan.</p>			

Name	Date of birth (mm/dd/yyyy)	Primary care name, address
	___ / ___ / ____	
	___ / ___ / ____	
	___ / ___ / ____	
	___ / ___ / ____	
	___ / ___ / ____	
	___ / ___ / ____	

Cancellation

Please check this box if you are canceling your current coverage with BCBSRI.

continued ►

Section 3 TERMS, CONDITIONS, AND SIGNATURES

By signing this form, I acknowledge and agree that:

- I understand the medical plan benefits I have selected, including the deductible and out-of-pocket maximums.
- This change will not apply until the coverage is made effective by BCBSRI.
- Upon BCBSRI's approval, BCBSRI will send me new medical plan information and new ID cards.
- This medical plan change shall apply to me and all enrolled dependents.
- I am responsible for sharing benefit information with my enrolled family members covered under this policy.
- I certify that I have read the above statements or that they have been read to me and that the statements herein are true and complete to the best of my knowledge and belief.



Signature of Applicant or signature of parent or guardian
if applicant is under 18 years of age

Date

*For changes effective January 1, 2016, please return this form by December 7, 2015, to ensure a smooth transition into your new 2016 plan.

Mail: **Blue Cross & Blue Shield of Rhode Island**
Membership Department
500 Exchange Street
Providence, Rhode Island 02903-2699

Or Fax: **(401) 459-2385**

For questions, call: **(401) 459-5000 or 1-800-639-2227**
Representatives are available Monday
through Friday from 8:00 a.m. to 8:00 p.m.



500 Exchange Street • Providence, RI 02903-2699

Blue Cross & Blue Shield of Rhode Island
is an independent licensee of the Blue Cross and Blue Shield Association.

08/15 DPAY-16652 • 8467