Blue Cross Blue Shield of Rhode Island

Plans for Individuals and Families
Medical and Dental Plan Option Change Form

EXISTING MEMBERS MAY USE THIS FORM TO REQUEST A MEDICAL AND/OR DENTAL PLAN CHANGE

Please be sure to complete ALL information below to avoid delays in processing.
(This form can only be used for making a medical or dental plan change.)

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

Section 1 Member Information

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

Home address _____

City/town _____ State _____ ZIP code _____

Mailing address (if different from home address) _____

City/town _____ State _____ ZIP code _____

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Gender ☐ M ☐ F Social Security number[1] _____ - _____ - _____

Current BCBSRI ID _____

Home phone number _____ - _____ - _____

Cell phone number _____ - _____ - _____

Email address _____

What kind of a plan change are you making:

- ☐ Medical only (complete section 2)
- ☐ Dental only (complete section 3)
- ☐ Medical and dental (complete sections 2 and 3)

[1]Social 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

continued ➤

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): ____ / ____ / _____

VantageBlue Direct	BlueSolutions for HSA Direct	BasicBlue Direct	BlueCHiP Direct
☐ $1,325/2,650 Gold	☐ $1,400/2,800 Gold	☐ $2,750/5,500 Gold	☐ $2,300/4,600 Gold
☐ $3,250/6,500 Gold	☐ $4,100/8,200 Silver	☐ $4,900/9,800 Silver	☐ $4,800/9,600 Silver
☐ $4,850/9,700 Silver	☐ $6,000/12,000 Bronze	☐ $6,850/13,700 Bronze	☐ Other _____

You must select a PCP for yourself and anyone on your plan, otherwise your enrollment may be delayed and your benefits may be reduced.

Name	Date of birth (mm/dd/yyyy)	Primary care provider name, address, city/town, state	National Provider ID (NPI)# (Find your PCP's NPI in their profile in the Find a Doctor tool on bcbsri.com)
	___ / ___ / _____		
	___ / ___ / _____		
	___ / ___ / _____		
	___ / ___ / _____		
	___ / ___ / _____		
	___ / ___ / _____		

Section 3 Dental Plan Options

Dental coverage applied for: (*please choose one*)

☐ Dental Direct Basic	☐ Dental Direct Plus
☐ Dental Direct Standard	☐ Dental Direct Elite

These are Qualified Dental Plans, which are certified as providing the pediatric dental essential health benefit.

continued ➤

Section 4 Dental Direct Disclosure Statement

- A 6-month waiting period applies to denture repairs on some plans.
- A 12-month waiting period applies to root canals, periodontal services, oral surgery, crowns, and prosthodontics on some plans.
- Waiting periods do not apply to members under the age of 19 enrolling in a qualified dental plan. If you terminate coverage and then re-apply, the waiting periods listed above will apply without accounting for your prior coverage.

Please note, when switching plans:

- If you have satisfied your waiting period on your current plan, the waiting period will not apply to your new plan. If you are switching plans and still in your waiting period, the waiting period will carry over and continue on your new plan.
- This will be your only opportunity to switch plans for Dental Direct coverage. Once you switch, you will not be able to change plans until the next open enrollment period, or during a special enrollment period.

Section 5 Terms, Conditions, and Signatures

By signing this form, I acknowledge and agree that:

- I understand the medical and dental plan benefits I have selected, including the deductible benefit maximums and out-of-pocket maximums, if applicable.
- This change will not apply until the coverage is made effective by BCBSRI.
- This medical and/or dental 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.

SIGN HERE ☞

Signature of applicant or parent/guardian *if applicant is under 18 years of age* Date

Please submit your Plan Option Change Form by using one of the methods below:

- Fax to: (401) 459-2385
- Mail to: Blue Cross & Blue Shield of Rhode Island
  Membership Department
  500 Exchange Street
  Providence, Rhode Island 02903-2699

Medical	Dental
For questions regarding your **MEDICAL** coverage, 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. Saturday and Sunday 8:00 a.m. to noon.	For questions regarding your **DENTAL** coverage, call: (401) 453-4700 or 1-800-831-2400 Representatives are available Monday through Friday from 8:00 a.m. to 8:00 p.m.

Blue Cross Blue Shield of Rhode Island

www.bcbsri.com

500 Exchange Street • Providence, RI 02903-2699