

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) /	_/ Ger	nder 🗌 M 🔲 F	Social security number	1	
Current BCBSRI ID				Cell phone number	
What is your primary language spoke	en?	E-m	ail address		
Race (please check one)					
American Indian or Alaska Native	🗌 Asian 🗌 B	lack or African Amer	ican 🔲 Hispanic or L	_atino	
Multiracial Native Hawaiian or	r other Pacific Isl	lander 🗌 White			
				continued \blacktriangleright	

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): ____/ ____/

VantageBlue Direct	VantageBlue Direct with Dental	BlueSolutions for HSA Direct	BasicBlue Direct
51,000/2,000 Gold	S1,200/2,400 Gold	🔲 \$1,400/2,800 Gold	5,500 Gold \$2,750/5,500 Gold
3,000/6,000 Silver		🔲 \$3,900/7,800 Silver	54,900/9,800 Silver
		🔲 \$3,700/7,400 Bronze	5,850/13,700 Bronze
		S,350/10,700 Bronze \$	
BlueCHiP Direct	I	I	I

\$4,500/9,000 Silver

You are required to select a primary care physician for yourself and dependents (if applicable) for this plan.

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.

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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

- 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.

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