Blue Cross Blue Shield of Rhode Island

Plans for Individuals and Families Health Plan Option Change Form

EXISTING MEMBERS MAY USE THIS FORM TO REQUEST A HEALTH 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	Suffix	First Name	M.I.

Date of birth (MM/DD/YYYY)	Social security number (XXX-XX-XXXX)*	Current BCBSRI ID

Home phone number	Cell phone number	Best time to call ☐ 9 a.m. to noon ☐ noon to 4 p.m. ☐ 4 p.m. to 7p.m.

Email address

What is your primary language spoken?	Communications preference ☐ U.S. mail ☐ Email ☐ Home phone ☐ Cell phone

Race (please check one)
☐ American Indian and Alaska Native ☐ Asian ☐ Black or African American
☐ Hispanic or Latino ☐ Multiracial ☐ Native Hawaiian and other Pacific Islander ☐ White

* 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-Group-Health-Plans/Overview.html

SECTION 2: HEALTH PLAN OPTIONS

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

Choose a Health Plan Option (please check one)**:**

Gold Level Plans		
☐ VantageBlue SelectRI Direct $500/1,000	☐ VantageBlue Direct $1,000/2,000	☐ BlueSolutions for HSA Direct $1,500/3,000
Silver Level Plans		
☐ BlueSolutions for HSA Direct $2,600/5,200	☐ VantageBlue Direct $3,000/6,000	☐ VantageBlue SelectRI Direct $3,000/6,000

Bronze Level Plans			
☐ BlueSolutions for HSA Direct $2,400/4,800	☐ BlueSolutions for HSA Direct $5,000/10,000	☐ VantageBlue Direct $5,800/11,600	☐ VantageBlue SelectRI Direct $5,800/11,600

☐ BasicBlue Direct $6,350/12,700 - Specific eligibility rules apply to this plan.

continued

SECTION 3: TERMS, CONDITIONS, AND SIGNATURES

By signing this form, I understand:

- The health plan benefits being chosen, 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 health plan information and new ID cards.
- This health 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.

▶ ☐ By checking this box, you are attesting that you are either purchasing a Dental Direct plan from BCBSRI or you have purchased a Qualified Dental Plan certified by HealthSource RI. Based on this attestation, your medical plan will not include pediatric dental essential health benefits and your premium will be slightly lower.

Signature of Applicant or signature of parent or guardian *(if applicant is under 18 years of age)* Date

Please mail this form to: **Blue Cross & Blue Shield of Rhode Island**
Membership Department
500 Exchange Street
Providence, Rhode Island 02903-2699

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.

Blue Cross Blue Shield of Rhode Island

500 Exchange Street • Providence, RI 02903-2699

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