BlueCross BlueShield of Tennessee

- CONFIDENTIAL -

801 Pine Street
Chattanooga, TN 37402-2555
www.bcbst.com

ADD DEPENDENT / CHANGE REQUEST

PLEASE USE BLUE OR BLACK INK ONLY

Plan Use Only
Rec:_____

ADC-05

Section 1 – Select Type of Change - Please mark all that apply

☐ Add/Change Dependent(s) ☐ Add/ Change Medical Coverage ☐ Change Life Beneficiary

☐ Change Name/Date of Birth ☐ Add/Change Dental Coverage ☐ Add/Change Life Coverage

☐ Change Address/Phone No. ☐ Change Department ☐ Change Salary

☐ Change Subgroup

GROUP NO. GROUP NAME

EMPLOYEE LAST NAME EMPLOYEE FIRST NAME MI

IDENTIFICATION NO:

Section 2 – Currently Enrolled Employee - You only need to fill in the sections you want to change

Change my address to: STREET

CITY (PLEASE DO NOT ABBREVIATE) STATE ZIP DAYTIME PHONE NO. (Area Code)

Change my name to: LAST NAME FIRST NAME MI JR., SR., ETC. REASON FOR NAME CHANGE: DATE OF BIRTH M M D D Y Y Y Y

Add/change medical option: ☐ 1 ☐ 2 ☐ 3 ☐ 4 Other ❑ Ind ❑ Fam ❑ EE/Spouse ❑ EE/Child(ren) Effective: M M D D Y Y

HAVE YOU HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? ☐ YES ☐ NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE? From M M D D Y Y To M M D D Y Y

Add/change dental option: ☐ 1 ☐ 2 ☐ 3 ☐ 4 Other ❑ Ind ❑ Fam ❑ EE/Spouse ❑ EE/Child(ren) Effective: M M D D Y Y

Reason for change: ☐ Open Enrollment ☐ Marriage ☐ New Dependent Child ☐ Loss of Other Medical Coverage ☐ Loss of Other Dental Coverage ☐ Court Order Event Date: M M D D Y Y

Other changes: Subgroup No. Dept No. Effective: M M D D Y Y

Section 3 – Dependent Adds / Changes (Additional dependents on back). Consult Employer Guidelines for Dependent Eligibility.

SPOUSE LAST NAME SPOUSE FIRST NAME MI JR., SR., ETC. Male ☐ Female ☐ DATE OF BIRTH M M D D Y Y Y Y SOCIAL SECURITY NO.*

HAS SPOUSE HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? ☐ YES ☐ NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE? From M M D D Y Y To M M D D Y Y

DEPENDENT LAST NAME DEPENDENT FIRST NAME MI JR., SR., ETC. Male ☐ Female ☐ DATE OF BIRTH M M D D Y Y Y Y SOCIAL SECURITY NO.*

☐ Natural Child / Stepchild ☐ Adopted / Legal Guardian Other (specify) ❑ Physically Handicapped ❑ Fulltime Student Over 19

HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? ☐ YES ☐ NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE? From M M D D Y Y To M M D D Y Y

Section 4 – Acknowledgement - Signature and Date MUST BE COMPLETED

If you or listed dependents will be covered by other health, dental or Medicare insurance when this plan goes into effect, indicate which coverage. ☐ Medical/Medicare ☐ Dental

HICN

I understand, and agree, that I am applying for coverage and: 1) that any contract which may be issued to me will be subject to all the terms and conditions of the Group Agreement; 2) that my signature on this form will authorize any doctor, hospital, or other provider of treatment to furnish BlueCross BlueShield of Tennessee any and all medical records pertaining to any person covered by the contract and that; 3) I am responsible for any fee for these records.

Employee's Signature: X Date: M M D D Y Y

* To comply with Federal regulations we must have a Social Security Number.

A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

GROUP NO. EMPLOYEE LAST NAME EMPLOYEE FIRST NAME **ADC-05**

Section 5 – Dependent Information (Continued from Section 3)

DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | JR., SR., ETC. | Male ☐ Female ☐ | DATE OF BIRTH (M M D D Y Y Y Y) | SOCIAL SECURITY NO.*

☐ Natural Child / Stepchild ☐ Adopted / Legal Guardian Other (specify) ❑ Physically Handicapped ❑ Fulltime Student Over 19

HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? ☐ YES ☐ NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE? From (M M D D Y Y) To (M M D D Y Y)

DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | JR., SR., ETC. | Male ☐ Female ☐ | DATE OF BIRTH (M M D D Y Y Y Y) | SOCIAL SECURITY NO.*

☐ Natural Child / Stepchild ☐ Adopted / Legal Guardian Other (specify) ❑ Physically Handicapped ❑ Fulltime Student Over 19

HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? ☐ YES ☐ NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE? From (M M D D Y Y) To (M M D D Y Y)

DEPENDENT LAST NAME | DEPENDENT FIRST NAME | MI | JR., SR., ETC. | Male ☐ Female ☐ | DATE OF BIRTH (M M D D Y Y Y Y) | SOCIAL SECURITY NO.*

☐ Natural Child / Stepchild ☐ Adopted / Legal Guardian Other (specify) ❑ Physically Handicapped ❑ Fulltime Student Over 19

HAS DEPENDENT HAD CONTINUOUS HEALTH COVERAGE FOR THE PAST 12 MONTHS? ☐ YES ☐ NO IF NO, WHAT ARE THE DATES OF MOST RECENT COVERAGE? From (M M D D Y Y) To (M M D D Y Y)

Section 6 – Life Insurance Information (Life insurance and related products are underwritten by independent life insurance carriers) (If Beneficiary Percentage is left blank, benefits will be divided equally among beneficiaries.)

DROP (Mark all that apply)

☐ Dependent Life ☐ STD ☐ LTD

ADD/CHANGE (Mark all that apply)

Change Life Class to: ☐ Basic Life/ADD ☐ Dependent Life ☐ STD ☐ LTD ☐ Supplemental Life/ADD

CHANGE EFFECTIVE: (M M D D Y Y)

EVENT DATE: (M M D D Y Y)

REASON: ☐ Marriage ☐ New Dependent Child

ANNUAL SALARY: $ .00

BASIC LIFE INSURANCE AMT $ .00 OR TIMES SALARY

SUPPLEMENTAL LIFE/ADD AMT $ .00 OR TIMES SALARY

BENEFICIARY	RELATIONSHIP	PERCENTAGE	BENEFICIARY	RELATIONSHIP	PERCENTAGE
1			3		
2			4		

Signature of Witness to Change of Beneficiary:

Section 7 – Waiver of Coverage - Complete this section to waive coverage, however, your Employer may require an additional separate waiver form.

DECLINE COVERAGE – I understand that I have been offered, and have declined, coverage sponsored by my employer.

Medical ❑ Dental ❑ Basic Life/ADD ❑ Dependent Life ❑ STD ❑ LTD ❑ Supplemental Life/ADD ❑

Reason for declining: (Mark all that apply)

❑ Other group medical coverage ❑ Other group dental coverage ❑ I have TennCare ❑ Other

GROUP NO. GROUP NAME

EMPLOYEE LAST NAME EMPLOYEE FIRST NAME EMPLOYEE DATE OF BIRTH (M M D D Y Y Y Y)

WAIVER SIGNATURE (Note: Signature also required in Section 4 when electing any coverage)

X

DATE (M M D D Y Y)

Special Enrollment Period for Medical and Dental: An Employee or eligible dependent who did not apply for Coverage within thirty-one (31) days of first becoming eligible for Coverage under this Plan may enroll if: 1) he or she had other health care coverage at the time Coverage under this plan was previously offered; and 2) he or she stated, in writing, at the time Coverage under this Plan was previously offered, that such other coverage was the reason for declining Coverage under this Plan; and 3) such other coverage is exhausted (if the other coverage was continuation coverage under COBRA) or the other coverage was terminated because he or she ceased to be eligible due to involuntary termination or employer contributions for such coverage ended; and 4) he or she applies for coverage under this Plan and the administrator receives the change form within thirty-one (31) days after the loss of other coverage. The Employee may also enroll at the next Open Enrollment Period.