

# REQUEST FOR CHANGE IN MEMBERSHIP

## NO HEALTH STATEMENT REQUIRED



**BlueCross BlueShield  
of Oklahoma**

*Experience. Wellness. Everywhere.®*

Please submit this form via one of the following methods:

**MAIL:** P.O. Box 3238  
Naperville, IL 60566-7238

**FAX:** 1-800-279-7419

Questions? Please call our Customer Service Department toll-free at 1-866-520-2507.

**CHECK ALL THAT APPLY:**  Downgrade  Transfer Spouse and / or Dependent(s) to Own Policy  Change Financial Institutions

### SECTION A – PRIMARY APPLICANT INFORMATION PLEASE PRINT

PRIMARY APPLICANT – person applying for coverage

FIRST NAME, MIDDLE INITIAL, LAST NAME		SOCIAL SECURITY NO.	
RESIDENTIAL ADDRESS, NO P.O. BOXES (STREET, CITY, STATE, ZIP+4)			
MAILING ADDRESS (STREET, CITY, STATE, ZIP+4) if different than above		EMAIL (if available and acceptable contact method)	
HOME PHONE ( ) ( )	WORK PHONE ( ) ( )	SPOUSE'S NAME	SPOUSE'S SOCIAL SECURITY NO.

- TOBACCO USE STATUS** – Have you or your spouse, if insured, smoked cigarettes or used tobacco in any form in the last 12 months?  
Applicant .....  Yes  No  
Spouse .....  Yes  No
- MATERNITY COVERAGE** – If you have maternity coverage, do you want maternity coverage to continue? .....  Yes  No  
IF YOU ARE WANTING TO ENROLL IN MATERNITY COVERAGE, A DIFFERENT FORM IS NEEDED. PLEASE CONTACT THE CUSTOMER SERVICE DEPARTMENT AT THE NUMBER LISTED ABOVE.
- PRIMARY POLICYHOLDER OF CURRENT POLICY** (if different than above): \_\_\_\_\_  
SOCIAL SECURITY NO.: \_\_\_\_\_ POLICY NO.: \_\_\_\_\_
- DEPENDENT CHILDREN** – Note: You may only change coverage for children, under 26 years of age, who are now covered under the current Blue Cross and Blue Shield of Oklahoma health insurance policy. List all children this application applies to:

Names of Dependent Children Enrolled	Age	Names of Dependent Children Enrolled	Age
_____	_____	_____	_____
_____	_____	_____	_____

### SECTION B – COVERAGE REQUESTED CHOOSE ONE PLAN AND ONE DEDUCTIBLE

- |   |  |
|---|--|
| <input type="checkbox"/> <b>HEALTH CHECK BASIC</b><br>CHOOSE ONE DEDUCTIBLE:<br><input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 | <input type="checkbox"/> <b>HEALTH CHECK SELECT</b><br>CHOOSE ONE DEDUCTIBLE:<br><input type="checkbox"/> \$200 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 |
|---|--|

**HEALTH CHECK HSA** FEDERAL LAW SPECIFIES MINIMUM DEDUCTIBLES FOR THIS PRODUCT WHICH ARE SUBJECT TO COST OF LIVING ADJUSTMENTS.:

**FOR INDIVIDUAL COVERAGE<sup>1</sup>:**

Deductible	Coinsurance <sup>2</sup>	Out-of-Pocket Maximum <sup>3</sup>
<input type="checkbox"/> \$1,500	80%	\$3,000
<input type="checkbox"/> \$2,500	80%	\$4,000
<input type="checkbox"/> \$2,500	100%	\$2,500
<input type="checkbox"/> \$3,500	80%	\$5,000
<input type="checkbox"/> \$3,500	100%	\$3,500
<input type="checkbox"/> \$5,000	100%	\$5,000

**FOR FAMILY COVERAGE<sup>1</sup>:**

Deductible	Coinsurance <sup>2</sup>	Out-of-Pocket Maximum <sup>3</sup>
<input type="checkbox"/> \$3,000	80%	\$6,000
<input type="checkbox"/> \$5,000	80%	\$8,000
<input type="checkbox"/> \$5,000	100%	\$5,000
<input type="checkbox"/> \$7,000	80%	\$10,000
<input type="checkbox"/> \$7,000	100%	\$7,000
<input type="checkbox"/> \$10,000	100%	\$10,000

<sup>1</sup>By federal law if you are listed as a dependent on another person's federal income tax return, you are not eligible to participate in the tax-qualified benefits of an HSA plan.  
<sup>2</sup>The percentage for coinsurance is based on allowable charges for covered services received from in-network providers. <sup>3</sup>Out-of-pocket maximum includes deductible.

### SECTION C – FINANCIAL INSTITUTION ACCOUNT CHANGE IF APPLICABLE

**IMPORTANT:** Please indicate what account your monthly premium will be deducted from: .....  CHECKING  SAVINGS  
 Monthly premiums are deducted automatically from participating Oklahoma banks, credit unions or saving and loans.

- Please provide the following information regarding your financial institution and/or account number change and attach a VOIDED personal check or savings deposit slip, from a participating Oklahoma financial institution, with your new account information.
- I hereby request and authorize Blue Cross and Blue Shield of Oklahoma to initiate debit entries to my account on or around the date payment is due
- I understand that this is not an employer group health plan and is not intended, in any way, to be an employer-sponsored health insurance plan
- I certify the employer(s) of those applying for coverage will not contribute any part of the premium, or provide reimbursement for any part of the premium now or in the future.
- PLEASE ENSURE ADEQUATE FUNDS ARE AVAILABLE AT THE TIME OF APPLICATION. BLUE CROSS AND BLUE SHIELD OF OKLAHOMA IS NOT RESPONSIBLE FOR FEES INCURRED DUE TO INSUFFICIENT FUNDS.

NAME OF ACCOUNT HOLDER (PLEASE PRINT)	SIGNATURE OF ACCOUNT HOLDER (AUTHORIZES DEDUCTION FROM NEW ACCOUNT)	RELATIONSHIP TO MEMBER	DATE SIGNED
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# SECTION D – REPRESENTATIONS, ACKNOWLEDGEMENTS AND AUTHORIZATIONS

I and any persons whose names appear on this form hereby request a modification to the current health insurance plan from Blue Cross and Blue Shield of Oklahoma. This is a Request for Change in Membership and I should not cancel any existing coverage unless and until I am notified in writing by Blue Cross and Blue Shield of Oklahoma of acceptance.

I understand, certify and agree to the items listed below:

- Any insurance agent, examining physician, or other person who knowingly and willfully makes a false or fraudulent statement or representation in or relative to any application of insurance, or who makes such statement to obtain a fee, commission, money or benefit shall be guilty of a misdemeanor according to TITLE 36, SECTION 1204 of the Oklahoma State Statutes.
- If someone, other than myself, has completed any portion of this change request on my behalf, I have reviewed the information and agree it is accurately reflected.
- The primary applicant is a resident of, and has principal residence located within, the State of Oklahoma and understands that proof of residency may be required at any time.
- This coverage is not an employer-group health plan and is not intended in any way to be an employer sponsored health insurance plan. Further, I certify that my employer will not contribute any part of the premium, nor will I be reimbursed for any part of the premium by my employer now, or in the future.
- Maternity coverage must be in effect for 365 days prior to delivery before maternity benefits will be available.
- I understand that an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact, with the intent to deceive the Plan, on this application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. I will be provided with at least 30 days' advance written notice before my or my dependent's coverage may be rescinded, retroactive to the effective date of coverage.
- This is an age-related health plan. Rates are subject to change based upon age and other factors.
- This change form when processed may result in acceptance or denial.
- Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

**WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.**

PRIMARY APPLICANT'S SIGNATURE (AGE 15 AND OVER)   X   \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

SPOUSE'S SIGNATURE (IF APPLYING)   X   \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

PARENT OR LEGAL GUARDIAN'S SIGNATURE (IF PRIMARY APPLICANT IS UNDER AGE 18)   X   \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)   X   \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)   X   \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)   X   \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

**PROXY STATEMENT:** The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters (300 E. Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

**Primary Applicant's Signature**

  X  

Print Your Name as You Signed It: \_\_\_\_\_ Date Signed \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

# SECTION E – AGENT INFORMATION *(if applicable)*

AGENT'S SIGNATURE	DATE	AGENT'S CODE
PRINT AGENT'S NAME	AGENT'S PHONE	AGENT'S FAX