

SimplyBlue REQUEST FOR CHANGE IN MEMBERSHIP

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.



**BlueCross BlueShield
of Oklahoma**

Experience. Wellness. Everywhere.®

SECTION A – PRIMARY APPLICANT INFORMATION PLEASE PRINT

PRIMARY APPLICANT (Must be age 19 or older)

FIRST NAME, MIDDLE INITIAL, LAST NAME			SOCIAL SECURITY NO.
RESIDENTIAL ADDRESS, NO P.O. BOXES (STREET, CITY, STATE, ZIP+4)			EMAIL (if available and acceptable contact method)
MAILING ADDRESS (STREET, CITY, STATE, ZIP+4) <i>if different than above</i>			CELL PHONE ()
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
- PRIMARY POLICYHOLDER OF CURRENT POLICY** (if different than above): _____
SOCIAL SECURITY NO.: _____ POLICY NO.: _____
- DEPENDENT CHILDREN** – Note: You may only change coverage for children who are now covered under the current Blue Cross and Blue Shield of Oklahoma health insurance policy. List all children this application applies to (dependent children must be under age 26):

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

SECTION B – COVERAGE CHANGE SELECT ONE DEDUCTIBLE AND INDICATE IF DENTAL CHANGE IS REQUIRED

- DEDUCTIBLE** Choose only one. Deductible applies to in-network services only. Additional deductibles apply for services received out-of-network.
- \$1,000 \$2,000 \$3,000 \$5,000 \$7,500 \$10,000
- OPTIONAL: ADD BLUECARE DENTAL** – I (We) hereby apply for Dental coverage and understand that all Applicants and Dependents approved for health coverage will be covered under the Dental coverage. If any covered health individual is cancelled from the health coverage or if health coverage is cancelled in its entirety, I understand the same action will be applied to Dental coverage. I also understand that if I or any of my dependents are currently Blue Cross and Blue Shield of Oklahoma Voluntary Individual Dental plan members, the VID plan will be cancelled and replaced by this dental addendum without a gap in coverage.
- OPTIONAL: REMOVE BLUECARE DENTAL** – I (We) hereby disenroll in Dental coverage and understand that all Applicants and Dependents with health coverage will no longer receive Dental coverage benefits. In addition, if any covered health individual is cancelled from the health coverage or if health coverage is cancelled in its entirety, I understand the same action will be applied to Dental coverage.

SECTION C – BILLING INFORMATION CHANGE IF APPLICABLE

- PREMIUM MODE:** Monthly Bank Draft (Must complete Authorization Agreement below.)
 One-Month Direct Bill
 Two-Month Direct Bill
 List Bill (Indicate Name of Employer below.)

Billing Name and Address (If different than applicant name and residential address. If an address is entered in this section, only the billing will be sent to this address; all other correspondence will be sent to the address in Section A, unless requested otherwise.)

FIRST NAME, MIDDLE INITIAL, LAST NAME
RESIDENTIAL ADDRESS, NO P.O. BOXES (STREET, CITY, STATE, ZIP+4)
NAME OF EMPLOYER (if requesting List Bill only)

AUTHORIZATION AGREEMENT – Required for Bank Draft Payments Only

I request and authorize Blue Cross and Blue Shield of Oklahoma (BCBSOK) and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. I understand that this request for coverage 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. I also understand that both the financial institution and BCBSOK reserve the right to terminate this payment program and/or my participation therein. To make changes to my financial institution I understand that I will need to provide at least 10 days advance notice to Blue Cross and Blue Shield of Oklahoma by telephone prior to a scheduled withdrawal date.

AUTHORIZATION AGREEMENT CONTINUED – PLEASE COMPLETE THE FOLLOWING – PRINT OR TYPE INFORMATION

I authorize BCBSOK to deduct the premium payments from my checking or savings account on the monthly premium due date. If the draft date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day.

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.

PLEASE CHECK ONE: Checking Account Savings Account

NAME OF DEPOSITOR(S) IF OTHER THAN THE APPLICANT: _____

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED: _____

BANK TRANSIT NUMBER: _____ DEPOSITOR'S ACCOUNT NUMBER: _____

I HAVE READ AND ACCEPT THE ABOVE AGREEMENT.

DEPOSITOR'S SIGNATURE: X _____ DATE: _____

RELATIONSHIP TO APPLICANT: _____

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.
- I am a resident of, and have principal residence located within, the State of Oklahoma and understand 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.
- 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-rated 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: _____

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