



EmployeeChoice Medical Plan Change Request Form

FAX your completed form to 805-499-0824



Please tell us who you are and how we can reach you:

Group No.	Company Name
Phone	Contact Name
FAX	Email

Be sure to complete this section to authorize these changes:

I am an owner or officer of this company and hereby authorize the following changes to our Blue Cross group medical coverage portfolio.

Signature _____ Print Name _____

Date _____ Requested Effective Date _____

For each member who wishes to change plans:
Provide member's name and identification number, and mark the plan the member wishes to be moved to.

New enrollees or family additions must complete an Employee application requesting coverage.

Member's Name	Member's Social Security or ID No.	Premier \$20 Copay	\$30 Copay	\$35 Copay GenRx	PPO 2400 (HSA-Comp)	Saver HMO	Saver HMO plan Provide 3 or 6-digit Primary Care Physician number here
1)							
2)							
3)							
4)							
5)							
6)							
7)							
8)							
9)							
10)							

Please photocopy form if additional rows are needed.