SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT
SUBSCRIBER CHANGE REQUEST

EMPLOYEE IDENTIFICATION

EMPLOYEE PIN	☐ ACTIVE ☐ RETIRED	☐ CERTIFICATED ☐ CLASSIFIED	☐ FULL TIME ☐ PART TIME

LAST NAME	FIRST NAME	M.I.	REQUESTED EFFECTIVE DATE
ADDRESS CITY STATE ZIP			IS THIS A NEW ADDRESS? ☐ NO ☐ YES
BUSINESS PHONE ( )	HOME PHONE ( )		

LIST THE QUALIFYING EVENT FOR SUBMITTING THIS CHANGE REQUEST:

INFORMATION CHANGES

CHECK ALL HEALTH PLAN OPTION(S) WHICH REQUIRE CHANGES:
☐ Blue Shield PPO ☐ Dental ☐ Vision ☐ Behavioral Health
☐ Blue Shield HMO (For HMO, complete physician information below)

(For Benefits Department Use Only)
Blue Shield Group: ____________________

Correct/Change my name **from**: Correct/Change my name **to**:

Other Type of Change:

Transfer my current coverage to: ☐ Blue Shield HMO ☐ Blue Shield PPO

(For Benefits Department Use Only)
To Group:

SELF OR SPOUSE/DOMESTIC PARTNER OR DEPENDENT COVERAGE CHANGES

NOTE: A SUBSCRIBER CHANGE FORM MUST BE SUBMITTED 31 DAYS FROM THE DATE OF MARRIAGE/DOMESTIC PARTNERSHIP OR BIRTH/ADOPTION TO BE ADDED TO THE EMPLOYEE'S COVERAGE (EXCEPTION: DURING OPEN ENROLLMENT)

☐ Add Spouse/Domestic Partner and/or Dependents (Complete section below)
Attach Marriage Certificate/Declaration of Domestic Partnership/Proof of Birth and most recent federal tax return or other legal documentation.

☐ Delete Spouse/Domestic Partner and/or Dependents (Complete section below)

Date of Marriage or Declaration of Domestic Partnership ____________________

Date of Divorce or Termination of Domestic Partnership ____________________

Date of birth, adoption, date placed for adoption ____________________

Add	Delete	Self/Dependent Personal Information		COMPLETE ONLY IF SELECTING BLUE SHIELD HMO HMO DIRECTORY INCLUDING PROVIDER #/IPA# AVAILABLE AT WWW.BLUESHIELDCA.COM	EXISTING PATIENT?
		SELF		DR. NAME ____ PROVIDER # ____ IPA/MG# ____	☐ NO ☐ YES
		☐ SPOUSE ☐ DOMESTIC PARTNER FIRST NAME	☐ MALE ☐ FEMALE LAST NAME	DR. NAME ____ PROVIDER # ____ IPA/MG# ____	☐ NO ☐ YES
		SOCIAL SECURITY #	DATE OF BIRTH		
		☐ SON ☐ DAUGHTER FIRST NAME	LAST NAME	DR. NAME ____ PROVIDER # ____ IPA/MG# ____	☐ NO ☐ YES
		SOCIAL SECURITY #	DATE OF BIRTH		
		☐ SON ☐ DAUGHTER FIRST NAME	LAST NAME	DR. NAME ____ PROVIDER # ____ IPA/MG# ____	☐ NO ☐ YES
		SOCIAL SECURITY #	DATE OF BIRTH		

LIFE INSURANCE DESIGNATION (SVEA/SVMTA/SVPSA-50% or more of a 40-hr work week; CSEA-More than 30 hours per week)

LIFE INSURANCE BENEFICIARY(IES): (For additional Beneficiaries, attach a list)

			Percentage*
NAME: ADDRESS:	DATE OF BIRTH:	SOCIAL SECURITY #: RELATIONSHIP:	%
NAME: ADDRESS:	DATE OF BIRTH:	SOCIAL SECURITY #: RELATIONSHIP	%

CONTINGENT LIFE INSURANCE BENEFICIARY(IES): Applicable only if you are not survived by one or more primary beneficiaries.

NAME: ADDRESS:	DATE OF BIRTH:	SOCIAL SECURITY #: RELATIONSHIP:	%
NAME: ADDRESS:	DATE OF BIRTH:	SOCIAL SECURITY #: RELATIONSHIP:	%

This beneficiary designation revokes all prior beneficiary designation. Unless you indicate otherwise, if any beneficiary predeceases you, that beneficiary's share will be divided pro-rata among the surviving beneficiaries of the same class-primary or contingent. If no beneficiary survives you, primary or contingent, payment will be made pursuant to the terms of the application policy. * If no percentages are indicated, benefits will be divided equally between the same class-primary or contingent.

EMPLOYEE SIGNATURE

2010

EMPLOYEE SIGNATURE: ____________________ DATE: ____________________