SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT
SUBSCRIBER CHANGE REQUEST
(MUST BE RECEIVED IN BENEFITS DEPT WITHIN 31 DAYS OF QUALIFYING EVENT)

EMPLOYEE IDENTIFICATION

EMPLOYEE PIN	☐ ACTIVE ☐ RETIRED ☐ COBRA	☐ SVEA ☐ SVMTA ☐ SVPSA ☐ CSEA (More than 6 hours per day) ☐ CSEA (6 hours per day or less)	
LAST NAME (PREVIOUS LAST NAME, IF CHANGING)	FIRST NAME	MIDDLE INTIAL	DATE OF BIRTH
LIST QUALIFYING EVENT THAT REQUIRES THIS CHANGE	DATE OF QUALYING EVENT	LEAVE THIS FIELD BLANK (EF/SS) /	

NAME/ADDRESS CHANGE OR TRANSFER OF MEDICAL PLAN

List new information (e.g., new name, new address, etc.):

Transfer my current medical coverage to (valid during Open Enrollment only): ☐ Blue Shield HMO ☐ Blue Shield PPO

BENEFIT COVERAGE(S) THAT REQUIRE CHANGE

☐ Blue Shield PPO and Optum Behavioral Health ☐ Blue Shield HMO and Optum Behavioral Health ☐ Dental And Vision

ADDING/DROPPING SELF AND/OR DEPENDENTS OR ESTABLISHING PROVIDER INFORMATION ONLY

- **To add Spouse/Domestic Partner** – Attach copy of Marriage Certificate/ Declaration of Domestic Partnership to this form.
- **To add Dependent(s)** – Attach proof of birth or court documentation establishing adoption or legal guardianship to this form. New births may provide non-certified proof of birth. Social Security # may be submitted at a later time.

COMPLETE ONLY IF ADDING BLUE SHIELD HMO
View full provider directory at: www.blueshieldca.com
Select Access+HMO as Plan and Sub Plan
Search by full name and zip code *or* zip code only
Medical Group # are located underneath Physician's Info
Incomplete designations are invalid

Add	Drop			Provider Information	EXISTING PATIENT?
		SELF		DR. FULL NAME ____ CITY OR ZIP CODE ____ PROVIDER # ____ MEDICAL GROUP NO. ____	☐ NO ☐ YES
		☐ SPOUSE ☐ DOMESTIC PARTNER FIRST NAME M.I. SOCIAL SECURITY #	☐ MALE ☐ FEMALE LAST NAME DATE OF BIRTH	DR. FULL NAME ____ CITY OR ZIP CODE ____ PROVIDER # ____ MEDICAL GROUP NO. ____	☐ NO ☐ YES
		☐ MALE ☐ FEMALE FIRST NAME M.I. SOCIAL SECURITY #	LAST NAME DATE OF BIRTH	DR. FULL NAME ____ CITY OR ZIP CODE ____ PROVIDER # ____ MEDICAL GROUP NO. ____	☐ NO ☐ YES
		☐ MALE ☐ FEMALE FIRST NAME M.I. SOCIAL SECURITY #	LAST NAME DATE OF BIRTH	DR. FULL NAME ____ CITY OR ZIP CODE ____ PROVIDER # ____ MEDICAL GROUP NO. ____	☐ NO ☐ YES
		☐ MALE ☐ FEMALE FIRST NAME M.I. SOCIAL SECURITY #	LAST NAME DATE OF BIRTH	DR. FULL NAME ____ CITY OR ZIP CODE ____ PROVIDER # ____ MEDICAL GROUP NO. ____	☐ NO ☐ YES

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

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

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

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

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

The above 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 noted, benefits will be divided equally between the same beneficiary class. All information contained here is true and correct to the best of my knowledge and I understand that it is my responsibility to report any qualifying events within 31 days of the event.

EMPLOYEE SIGNATURE: ________________ DATE: ________