



CHANGE FORM "E-27"

Attn: Membership #4
P.O. Box 30270
Salt Lake City, Utah 84130-0270

Regence BlueCross BlueShield of Utah is an independent licensee of the Blue Cross and Blue Shield Association.

SUBSCRIBER INFO

(PLEASE PRINT)

(Last Name) _____ (Initial) _____

(First Name) _____

Subscriber Identification Number: _____

Current Employer Group Name: _____

Current Employer Group Number: _____

INSTRUCTIONS

For name, address, family status and/or life beneficiary changes, please complete the appropriate section(s) below. All other changes should be reported on the "Application for Enrollment/Waiver" form. Leave all shaded areas blank for the use of Regence BlueCross BlueShield of Utah. Failure to complete all applicable information may result in a delay in processing your membership.

ADDRESS CHANGE

New Mailing Address or P.O. Box if applicable _____ (Street)

(City) _____ (State) _____ (Zip) _____ (Apt.) _____

NAME CHANGE

From: _____ To: _____ / _____ / _____

If reason for change is marriage, list **Date of Marriage** _____ and check appropriate space below:

I wish to add my spouse to my coverage and have accordingly listed his/her name in the "Additional Family Members" section.

I do not wish to add my spouse to my coverage

Effective Date	Membership Status	Adult Code	Family Members	Special Code	Medically Underwritten

Please complete the "Prior Coverage Information" form if you are adding a family member and if you are employed by a company with fewer than 51 employees who are eligible for health insurance.

ADDITIONAL FAMILY MEMBERS

Relationship to Subscriber	Full Name(s) of Member(s) to be Covered	Birthdate Mo/Day/Yr	Height Ft -- In	Weight Lbs.	Social Security Number For Each Dependent	Must Be Completed for Each Member Covered by Other Insurance (including Medicare)		
						Carrier Name	Medical	Dental Drug
		/ /	--					
		/ /	--					
		/ /	--					
		/ /	--					
		/ /	--					

DELETION OF MEMBERS	Relationship to Subscriber	Full Name(s) of Member(s) to be Deleted	For Each Change – List:	
			Reason	Effective Date
	Subscriber <input type="checkbox"/> M <input type="checkbox"/> F			
	Spouse <input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter			

LIFE CHANGES

If your life or disability insurance is administered by Regence Life and Health Insurance Company and you wish to make changes, please contact your Plan Administrator for further instructions.

If your life or disability insurance is administered by Highmark Life and Casualty (TransGeneral Life) and you wish to make changes, please provide the information below.

Beneficiary's Name (Last Name) _____ (First Name) _____ (Initial) _____ Relationship _____

Contingent Beneficiary (Last Name) _____ (First Name) _____ (Initial) _____ Relationship _____

Supplemental Group Life (if applicable): Amount _____

Life Carrier _____ Life Amount _____ Short Term Disability: Yes No
 Class _____ Dependent Life: Yes No Long Term Disability: Yes No

PRE-EXISTING CONDITIONS

Any coverage issued in connection with the addition of any family member through submission of this **Change Form E-27** may contain a limitation on the coverage of pre-existing conditions. If the added family member has prior creditable coverage, it may be available to reduce the period of the pre-existing condition limitation. We will assist the added family member in obtaining a certificate of creditable coverage, if necessary.

SIGNATURE

I, the undersigned, hereby request Regence BlueCross BlueShield of Utah, Regence HealthWise and/or Regence ValueCare, hereinafter known as "the Plan," to change my membership in the Plan as noted hereon, subject to prevailing rules, regulations and premiums of the Plan and in accordance with my present contract with the Plan. I understand any change in family status may affect my monthly premiums.

Association or other recognized arbitrator, a copy of which is available on request from the Plan. The Plan shall bear the costs of arbitration, filing fees, administrative fees and arbitrator fees. Other expenses of arbitration, including, but not limited to: attorney fees, expenses of discovery, witnesses, stenographer, translators, and similar expenses, will be borne by the party incurring those expenses. Any decision reached by arbitration shall be binding upon both you and the Plan. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

Any matter in dispute between you and the Plan may be subject to arbitration as an alternative to court action pursuant to the rules of, the American Arbitration Association or other recognized arbitrator, a copy of which is available on request from the Plan. The Plan shall bear the costs of arbitration, filing fees, administrative fees and arbitrator fees. Other expenses of arbitration, including, but not limited to: attorney fees, expenses of discovery, witnesses, stenographer, translators, and similar expenses, will be borne by the party incurring those expenses. Any decision reached by arbitration shall be binding upon both you and the Plan. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

Subscriber Signature _____ Date Signed _____