Employee Change Form (Medical, Dental and/or Vision)
For 1-100 Employee Small Groups

Empire BlueCross BlueShield
An Anthem Company

Consult the Evidence of Coverage for complete coverage terms and conditions.
Instructions: Complete electronically or in black ink and return to your employer. Please use extra sheets of paper if necessary.

Section A: General Information

Employer name			Group no.	Employer tax ID no.
Employee last name	Employee first name	M.I.	Employee Social Security no.[1] (required)	

Section B: Reason for Change(s)

Reason for change –Required. Select all that apply.

☐ Address change ☐ Add Spouse/Domestic Partner or dependent ☐ Enrollment in Medicare (Fill in Section E)
☐ Name change ☐ Cancel Spouse/Domestic Partner or dependent ☐ Cancel coverage
☐ Benefit change ☐ Change Primary Care Physician (PCP) ☐ Other:_____
☐ Change Primary Care Dentist (PCD)

Event reason. Select all that apply.
☐ Open enrollment* ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage ☐ Other insurance ☐ Death ☐ Divorce
☐ Termination of Employment ☐ Termination of Other Group Plan ☐ Court Ordered Coverage ☐ Other[2] - please explain: _____
Event date _____/_____/_____ **(MM/DD/YYYY)**
Effective date is subject to terms of the Evidence of Coverage. See "When Coverage Begins" under "Who is Covered".
*Leave Event Date field blank.

Home address — Street and PO Box if applicable	City	State	ZIP code

Retired? ☐ Yes ☐ No	Birthdate (MM/DD/YYYY) _____/_____/_____	Sex ☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Domestic Partner	Primary phone no.

Email address _____
I'm adding my email address above because I agree to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my benefits, so I will make sure Empire has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time and request a free copy of specific materials by mail. To do either, I will update my communication preferences by going to www.empireblue.com or calling Member Services.

PCP name[3]	PCP ID no.	Existing patient ☐ Yes ☐ No
PCD name[3]	PCD ID no.	Existing patient ☐ Yes ☐ No

Section C: Family Information — Spouse/Domestic Partner and dependents to be added/changed/cancelled. Attach a separate sheet if necessary.

☐ Add
☐ Change
☐ Cancel

Event reason - Required. Select all that apply.
☐ Open enrollment* ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other[2] - please explain: _____
Event date _____/_____/_____ **(MM/DD/YYYY)**
Effective date is subject to the terms of the Evidence of Coverage. See "When Coverage Begins" under "Who is Covered.
*Leave Event Date blank.

Spouse/Domestic Partner or Dependent Last name	First name	M.I.	Social Security no.[1] (required)

Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY) _____/____/_____	Relationship to applicant ☐ Spouse ☐ Domestic Partner ☐ Dependent

PCP name[3]	PCP ID	Existing patient ☐ Yes ☐ No
PCD name[3]	PCD ID	Existing patient ☐ Yes ☐ No

Does the Spouse/Domestic Partner or Dependent have a different address? ☐ Yes ☐ No
If yes, please enter: _____

1 Empire BlueCross BlueShield (Empire) is required by the Internal Revenue Service to collect this information.
2 See Evidence of Coverage description of "Special Enrollment Periods" under "Who is Covered" for other event reasons.
3 To select a PCP and/or PCD, visit our website at www.empireblue.com/find-doctor. If your Empire benefit plan requires you to pick a PCP and/or PCD and you do not select one, we will assign one to you. You will be able to change to another PCP and/or PCD by contacting us.

Employee name: ______________________________ Social Security no.: _______________

Section D: Plan/Type of Coverage	
1. Medical Coverage	
Medical product plan name:	Contract code:
Member medical coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family	
2. Dental Coverage	
Dental product plan name:	Contract code:
Member dental coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family	
3. Vision Coverage	
Vision product plan name:	Contract code:
Member vision coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family	

Section E: Prior and Other Group Coverage

Is anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No If yes, give name:_______________________________________

Medicare ID no.	Part A effective date (MM/DD/YYYY) / /	Part B effective date (MM/DD/YYYY) / /	Medicare eligibility reason (select all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date (MM/DD/YYYY) _____/______/________
Medicare Part D ID no.	Medicare Part D Carrier		Part D effective date (MM/DD/YYYY) / /

Is anyone applying for coverage covered by other health coverage? ☐ Yes ☐No If yes, please provide the following:

Name of person covered (Last, First, M.I.)	Type (select one)	Coverage (select all that apply)	Insurer name	Insurer phone no.	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: _____/_____/_____ End: _____/_____/_____
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: _____/_____/_____ End: _____/_____/_____
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: _____/_____/_____ End: _____/_____/_____
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: _____/_____/_____ End: _____/_____/_____

Section F: Terms, Conditions and Authorizations

In signing this Change Form, I represent that: Each Social Security number listed on this application is correct.

As an eligible employee, I am requesting coverage for myself and all the eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. I understand all benefits are subject to conditions stated in the Group Contract and Evidence of Coverage document.

I have read or have had read to me the application form.

Insurance Fraud Statement: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact there to, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim or each such violation.

Sign Here	Applicant signature X	Today's date (MM/DD/YYYY) / /
Sign Here	Company officer signature X	Today's date (MM/DD/YYYY) / /

Get help in your language

Language Assistance Services

Empire BlueCross BlueShield
An Anthem Company

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-748-1806). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-748-1806). (TTY/TDD: 711)

Albanian
Nëse ju nevojitet ndihmë për ta kuptuar këtë dokument në një gjuhë tjetër, mund ta kërkoni pa kosto shtesë duke telefonuar në numrin e shërbimeve për anëtarët (855-748-1806). (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-748-1806). (TDD/TTY: 711)

Bengali
একটি বিকল্প ভাষায় এই তথ্য পুস্তিকাটি বোঝার জন্য। যদি আপনার সহায়তার প্রয়োজন হয়, তাহলে কোনো অতিরিক্ত খরচ ছাড়া সদস্য পরিষেবা নম্বর (855-748-1806)-তে কল করে আপনি এটির অনুরোধ করতে পারেন। (TTY/TDD: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-748-1806)請求免費協助。(TTY/TDD: 711)

French
Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-748-1806. (TTY/TDD: 711)

Greek
Αν χρειαστείτε βοήθεια για να κατανοήσετε το παρόν έγγραφο σε άλλη γλώσσα, μπορείτε να τη ζητήσετε χωρίς πρόσθετο κόστος καλώντας τον αριθμό του Τμήματος Υπηρεσιών Μέλους (855-748-1806). (TTY/TDD: 711)

Haitian
Si ou bezwen èd pou konprann dokiman sa a nan yon lòt lang, ou kapab rele nimewo Manm Sèvis la pou mande asistans gratis nan nimewo (855-748-1806). (TTY/TDD: 711)

Italian
Se ha bisogno di assistenza per la comprensione del presente documento in un'altra lingua, può richiederla senza alcun costo aggiuntivo chiamando il numero dedicato ai Servizi per i membri (855-748-1806). (TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-748-1806)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Polish
Jeśli potrzebujesz pomocy w zrozumieniu niniejszego dokumentu w innym języku, możesz ją uzyskać bez ponoszenia dodatkowych kosztów, dzwoniąc do Działu Obsługi Klienta pod numer (855-748-1806). (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-748-1806). (TTY/TDD: 711)

Tagalog
Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-748-1806). (TTY/TDD: 711)

Urdu
تو آپ ممبر سروس نمبر پر کال اگر آپ کو کسی دوسری زبان میں اس دستاویز کو سمجھنے کے لیے مدد کی ضرورت ہو
جس کے لئے آپ پر کوئی اضافی اخراجات عائد نہیں ہوں گے نمبر کرکے اس کی درخواست کرسکتے ہیں
(711:TDD/TTY) (855-748-1806)

Yiddish
אויב איר דארפט הילף צו פארשטיין דעם דאקומענט אין אן אנדערע שפראך, קענט איר עס בעטן אהן קיין
עקסטערע קאסט דורך רופן די מעמבער באדינונגען נומער
(711:TDD/TTY) (855-748-1806)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.