Blue Cross Blue Shield Medical Change Form

Return Form to: General Synod, ARPC, 1 Cleveland Street, Greenville, SC 29601-3696

1. Please indicate reason for Application:

☐ **Add Dependent(s)** ☐ **Drop Dependents** ☐ **Change Premium Tier to Employee Plus 1**

☐ **Name Change** ☐ **Address Change**

2. EFFECTIVE DATE OF ACTION REQUESTED:

Month _____ Day ___ Year _____

3. Location: ☐ Erskine ☐ Due West ☐Bonclarken ☐ Other (Complete number 7 and circle classification in number 9 if applicable)

IDENTIFICATION (If for Name Change Enter Former Name: _____

4. Employee – Last Name First Initial	**5.** Social Security No.
6. Mailing Address (Street or P.O. Box) (City) (State) (Zip Code)	

7. Name of Employer	**8.** Blue Cross Group Number	**9. Retiree**	**10. Please circle**
General Synod, ARP Church	**71-53889**-☐☐-☐	**Disabled**	**Hourly**
Place of Employment: _____	Group Administrator Will Complete.	**COBRA**	**Salary**

11. Home Phone: _____ **12.** E-Mail Address: _____

TYPE MEMBERSHIP AND COVERAGE INFORMATION

13. Check type membership for coverage desired.

S – Single ☐ S+ – Single Plus 1 ☐ F – Family ☐

14. List All Family Members Covered or Affected By a Change

Last Name First Initial	Sex	Birth date Mo. Day Yr.	Last Name First Initial	Sex	Birth date Mo. Day Yr.
YOURSELF:					
Spouse			Child		
Social Security No.			Social Security No.		
Child			Child		
Social Security No.			Social Security No.		
Child			Child		
Social Security No.			Social Security No.		
Child			Child		
Social Security No.			Social Security No.		

OTHER INSURANCE INFORMATION

15. Are you Covered by the Federal Employees' Program (FEP) or Medicare? ☐ YES ☐ NO

If Yes: MEDICARE A ☐ Effective Date _____ MEDICARE B ☐ Effective Date_____

16. Are you or your dependents listed above covered on another group policy? EMPLOYEE: ☐ YES ☐ NO DEPENDENTS: ☐ YES ☐ NO

If Yes:

A. Insured's Name_____ and Social Security Number _____

B. Name of Insurance Co._____ Policy No._____ Effective Date _____

C. Family Member's Employer _____

D. List Names of Covered Persons 1. _____ 2._____ 3. _____ 4._____

E. **Please circle each type of service covered by this policy: Medical, Prescription Drugs**

EMPLOYEE CERTIFICATION

17. Employee Certification

Date: _____ Signature: _____