

# CHANGE OF STATUS

## FOR GROUP OR INDIVIDUAL COVERAGE

PLEASE PRINT IN INK

<b>Subscriber Information</b>	Last Name	First Name	MI	Subscriber ID Number		Date of Birth <small>(mo / day / yr)</small>
						/ /
Daytime Telephone						
<b>*** AUTHORIZATION SIGNATURE (PAGE 2) IS REQUIRED FOR ALL CHANGES ***</b>						
<b>Purpose</b>	SELECT ALL THAT APPLY AND COMPLETE THOSE SECTIONS					
	<input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Subscriber or Family Member(s) Cancellation <input type="checkbox"/> Personal Care Physician (PCP) Change		<input type="checkbox"/> Billing Change <input type="checkbox"/> Electronic Funds Transfer (EFT) Authorization  <b>***Authorization Signature (required for all changes)</b>			
<b>Name Change</b>		Last Name	First Name	MI		
	New Name					
	Old Name					
<b>Address Change</b>	Subscriber's City State ZIP					
	New Mailing Address					
	New Billing Address <small>(if different from mailing address)</small>					
<b>Subscriber or Family Member(s) Cancellation</b>	<small>If cancellation is a result of spouse and/or dependent child no longer being eligible, indicate the date of event (example: divorce, marriage, or death).</small>					
	Last Name	First Name	MI	Relationship	Reason for Change	Date <small>(mo / day / yr)</small>
						/ /
						/ /
						/ /
<b>Personal Care Physician (PCP) Change</b>	<b>IMPORTANT</b>		<b>New Personal Care Physician (PCP) and City Reason for Change</b>			
	Applies to members on Point-of-Service or HMO Plans only. Any changes must be approved by BCBSMT.		Member Name	(PCP) and City		Reason for Change

**OVER®**



**BlueCross BlueShield of Montana**

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Subscriber Name: \_\_\_\_\_  
 Subscriber ID No.: \_\_\_\_\_

<b>Billing Change</b>	<p><b>SELECT ALL THAT APPLY</b></p> <p><input type="checkbox"/> <b>Electronic Funds Transfer (EFT) to Direct Billing</b>          Direct Billing is not available for all products. Must complete address information on page 1. All billing statements will be mailed to the billing address.</p> <p><input type="checkbox"/> <b>Billing Address Change</b>          Complete billing address change on page 1.</p> <p><input type="checkbox"/> <b>Billing Frequency Change</b>          Check the appropriate billing frequency in the box to the right.</p> <p><input type="checkbox"/> <b>Direct Billing to EFT</b>          Complete the EFT section below.</p>	<p><b>BILLING FREQUENCY</b></p> <p><input type="checkbox"/> Monthly  <input type="checkbox"/> Quarterly  <input type="checkbox"/> Semi-Annually  <input type="checkbox"/> Annually</p>
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<b>Electronic Funds Transfer (EFT) Authorization</b>	<p style="text-align: center;"><b>IMPORTANT</b></p> <p><b>Electronic Funds Transfer (EFT) Authorization needs to be completed only if this is the payment method you have selected.</b></p>	<p><input type="checkbox"/> <b>Selecting Electronic Funds Transfer (EFT) payment method</b>          Indicate billing frequency above.</p> <p><input type="checkbox"/> <b>Making a change to current EFT payment method</b>          Example: new bank information or change in billing frequency.</p>
	<p>To _____          (Name, City, and State of Bank)</p>	
	<p>You are hereby authorized to honor Electronic Funds Transfer (EFT) drawn by Blue Cross and Blue Shield of Montana on my account, in payment of Blue Cross and Blue Shield of Montana dues at the prevailing rate. This authorization is to remain in force until revoked by me in writing through the Office of Blue Cross and Blue Shield of Montana, Helena, Montana.</p>	
	<p><b>Date</b> (mo / day / yr)</p>	<p><b>Subscriber ID</b></p>
	<p>/ /</p>	
	<p><b>Type of Account</b></p> <p><input type="checkbox"/> Checking Account  <input type="checkbox"/> Savings Account</p>	<p><b>Account Number</b></p>
	<p><b>PRINT Account Owner's Name</b></p>	<p><b>Account Owner's Signature</b>  <small>DO NOT PRINT</small></p>
	<p>***** ATTACH A DEPOSIT SLIP OR A VOIDED CHECK *****</p>	
<p>Blue Cross and Blue Shield of Montana agrees to pay to any bank or banker all sums of money, which said bank or banker shall become legally obligated to pay because of any deduction of money for Blue Cross and Blue Shield of Montana as hereon authorized by the bank customer whose signature appears above.</p>		

<b>Authorization Signature</b>	<p>I authorize Blue Cross and Blue Shield of Montana to make the changes to my policy as indicated above. The effective date for changes to a Personal Care Physician selection or cancellation of family member(s) will be assigned by Blue Cross and Blue Shield of Montana.</p>
<p style="text-align: center;"><b>Signature of Subscriber</b>  <small>DO NOT PRINT</small></p> <p>_____</p>	<p style="text-align: center;"><b>Date</b>  <small>(mo / day / yr)</small></p> <p style="text-align: center;">/ /</p>

**MAIL THE COMPLETED FORM TO:  
 Blue Cross and Blue Shield of Montana, P.O. Box 4309, Helena, MT 59604**