IB03

STATUS CHANGE FORM

Rev. 8/17

A. Subscriber Information

Name (First, Middle Initial, Last):			Gender:	Social Security Number:	Effective Date of Change:
Street Address:			City:	State:	ZIP Code:
Home Phone Number:	Cell Phone Number:	Work Phone Number:	E-Mail Address:		
Change Address and/or other information as noted above ☐			Medicare Number (if applicable):		

B. Status Change

(check all boxes requiring a change to existing coverage)

Coverage Type:	SEHIP	Blue Advantage	Supplemental	Optional	BCBS Dental	Southland Dental	Southland Cancer	Southland Vision	PCO
Cancel coverage	☐	☐	☐	☐	☐	☐	☐	☐	☐
Change from single to family coverage (complete Section C)	☐	☐	☐	☐	☐	☐	☐	☐	
Add dependent(s) listed below to family coverage (complete Section C)	☐	☐	☐	☐	☐	☐	☐	☐	
Change from family to single coverage (active employees must also complete Revoke Election Form – IB09)	☐	☐	☐	☐	☐	☐	☐	☐	
Cancel dependent(s) listed below from family coverage (complete Section C)	☐	☐	☐	☐	☐	☐	☐	☐	

Reason for Status Change(s) (check all that apply and provide documentation listed in parentheses):

☐ Open enrollment – change effective January 1st	☐ Marriage (marriage certificate within 60 days of qualifying event)
☐ Adoption of child (adoption papers within 60 days of qualifying event)	☐ Marriage of dependent child
☐ Birth of a child (birth certificate within 60 days of qualifying event)	☐ Termination of member/spouse/dependent employment
☐ Death of spouse/dependent: Date: _____	☐ Commencement of spouse/dependent employment
☐ Qualifying loss of coverage (proof of loss of coverage within 30 days of qualifying event)	☐ Spouse's employer with different open enrollment period
☐ Divorce/Annulment/Legal Separation (divorce decree within 30 days of qualifying event)	☐ Medicare/Medicaid entitlement (copy of card)
☐ Legal custody of a child (legal custody papers within 60 days of qualifying event)	☐ Adding former state employee: Last work day: _____
Date Change Occurred: _____	☐ Other _____

C. Dependent Information - Attach Separate Sheet, if necessary

First Name Middle Initial Last Name	Relationship to Employee*	Gender	Date of Birth	Social Security Number

* Documentation of relationship to employee is required for all plans except Supplemental Coverage Plan (e.g., social security number, marriage certificate, birth certificate, court decree). **IMPORTANT:** To be eligible for the non-tobacco and/or wellness discount, you must submit a completed Non-Tobacco User Discount Application and meet the requirements of the Wellness Program. When adding a spouse to SEHIP coverage, a spousal surcharge of $50 per month will be applied. To receive a discount you must submit a completed Spousal Surcharge Waiver Application (IB25). Forms are available at www.alseib.org.

AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity, or representative acting on the State's behalf.

Employee Signature: _____ Date: _____

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