

Section 3

To drop family members complete this section

Date of occurrence _____
Mo. Day Yr.

Check one:

- Change to employee only Change to employee/child(ren)
- Change to employee/spouse Retain family and terminate coverage for:

Give reason:

- Divorce Child reaching age limit Death Child married Other _____

Last	Name First	M.I.	Date of Birth		
			Mo	Day	Yr

Section 4

To change the Primary Care Physician complete this section**

Check reason
for change:
If dissatisfied with
PCP please
check reason:

- | | | | |
|----|---|----|--|
| AA | Dissatisfaction with Office Staff | AF | Dissatisfaction with Physician's Referral Policy |
| AB | Dissatisfaction with Medical Care/Services Rendered | AG | Less Respect and Attention Time Given than to Other Patients |
| AC | Inconvenient Office Location | AH | Patient Moved to New Location |
| AD | Dissatisfaction with Office Hours | AI | No Reason Given |
| AE | Unable to Schedule Appointments in a timely manner | AJ | Appointment Times not Met in a Timely Manner |

Last	Name First	M.I.	New Primary Care Physician		
			First	Last	City

**Complete if changing PCP on Blue Select or Premier Blue only.
 Change will be effective the first of the month following receipt of request.

Section 5

To change name, address and phone number, complete this section**

- Change name to _____
Last First M.I.
- Change address to _____
Street or Box Number

City County State ZIP
- Change telephone number to () _____

**If Blue Select or Premier Blue, address change may require PCP change.

Section 6

Other changes and comments

I hereby apply for a change in my enrollment.

Signature _____ Date ____/____/____
 Signature of group administrator _____ Date ____/____/____