CHANGE OF STATUS

FOR GROUP OR INDIVIDUAL COVERAGE

PLEASE PRINT IN INK

Subscriber Information

Last Name	First Name	MI	Subscriber ID Number	Date of Birth (mo / day / yr)
				/ /
				Daytime Telephone

***** AUTHORIZATION SIGNATURE (PAGE 2) IS REQUIRED FOR ALL CHANGES *****

Purpose

SELECT *ALL* THAT APPLY AND COMPLETE THOSE SECTIONS

- ❑ Name Change
- ❑ Address Change
- ❑ Subscriber or Family Member(s) Cancellation
- ❑ Personal Care Physician (PCP) Change
- ❑ Billing Change
- ❑ Electronic Funds Transfer (EFT) Authorization

***Authorization Signature (required for all changes)

Name Change

	Last Name	First Name	MI
New Name			
Old Name			

Address Change

	Subscriber's	City	State	ZIP
New Mailing Address				
New Billing Address (if different from mailing address)				

Subscriber or Family Member(s) Cancellation

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).

Last Name	First Name	MI	Relationship	Reason for Change	Date (mo / day / yr)
					/ /
					/ /
					/ /

Personal Care Physician (PCP) Change

IMPORTANT

Applies to members on Point-of-Service or HMO Plans only. Any changes must be approved by BCBSMT.

Member Name	New Personal Care Physician (PCP) and City	Reason for Change

OVER→

BlueCross BlueShield of Montana

An Independent Licensee of the Blue Cross and Blue Shield Association

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Subscriber Name:____________________
Subscriber ID No.:____________________

Billing Change

SELECT ALL THAT APPLY

- ❑ **Electronic Funds Transfer (EFT) to Direct Billing**
  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.
- ❑ **Billing Address Change**
  Complete billing address change on page 1.
- ❑ **Billing Frequency Change**
  Check the appropriate billing frequency in the box to the right.
- ❑ **Direct Billing to EFT**
  Complete the EFT section below.

BILLING FREQUENCY

- ❑ Monthly
- ❑ Quarterly
- ❑ Semi-Annually
- ❑ Annually

Electronic Funds Transfer (EFT) Authorization

IMPORTANT
Electronic Funds Transfer (EFT) Authorization needs to be completed only if this is the payment method you have selected.

- ❑ **Selecting Electronic Funds Transfer (EFT) payment method**
  Indicate billing frequency above.
- ❑ **Making a change to current EFT payment method**
  Example: new bank information or change in billing frequency.

To ____,
(Name, City, and State of Bank)

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.

Date (mo / day / yr)	Subscriber ID
/ /	
Type of Account	**Account Number**
❑ Checking Account ❑ Savings Account	
PRINT Account Owner's Name	**Account Owner's Signature** DO NOT PRINT

******** **ATTACH A DEPOSIT SLIP OR A VOIDED CHECK** ********

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.

Authorization Signature

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.

Signature of Subscriber DO NOT PRINT ____________________

Date (mo / day / yr) / /

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