Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

Policy Change Request

Policyholder name (please print) ______________________________

NOTE: All family members currently active on this policy will be evaluated for this change unless you specifically indicate otherwise.

Agent Name ____________________ Agent Number ____________________

Type of Request (check one) - Most changes are effective the first of the month following receipt of this form.

- ❒ **Change current individual plan to lesser benefits.** Select plan and complete signature area below.
- ❒ **Move to an individual plan from an active group plan.** If moving to lesser benefits, select plan and complete questions below. If moving to better benefits, discard this form and complete an Idaho Individual Application. **Group Cancel Date:** ____________
- ❒ **Review renewal rate.** Select plan and complete all questions below.
- ❒ **Move to better benefits.** DISCARD THIS FORM AND COMPLETE AN IDAHO INDIVIDUAL APPLICATION.

Plan Selection

Regence NowSelect	Regence Summit	Regence HSA HealthPlan
Regence NowSelect is a limited health benefit plan. Please read your product brochure carefully for details.	❒ $2,500 Deductible	❒ $1,500 Deductible (Individuals Only)
❒ $1,000 Deductible	❒ $5,000 Deductible	❒ $2,500 Deductible (Individuals Only)
❒ $2,500 Deductible	❒ $7,500 Deductible	❒ $3,500 Deductible (Individuals Only)
❒ $5,000 Deductible		❒ $3,000 Family Deductible (Families Only)
❒ $7,500 Deductible		❒ $5,000 Family Deductible (Families Only)
		❒ $7,000 Family Deductible (Families Only)

Detailed benefit information can be found in your Product Brochure or online at www.regence.com

1. ❑ Yes ❑ No Are you a resident of the state of Idaho? **If Yes:** ________ years ________ months
2. ❑ Yes ❑ No Are you, your spouse, mate or any eligible dependent child, whether or not listed on this application, now pregnant?
   If Yes, list name and relationship to self ____________________ Due date ____________
   Please list complications anticipated: ____________________ Multiple birth? ________
3. ❑ Yes ❑ No Have you or any family member on this policy used tobacco during the last 12 months?
   If Yes, list name(s): ____________________
4. ❑ Yes ❑ No Has future surgery, diagnostic testing or medical treatment been advised for any person listed on this application?
   If Yes, give details: ____________________
5. ❑ Yes ❑ No Have you or any enrolled family members consulted with a physician or been hospitalized in the past 90 days?
   If Yes, please complete the following:

Patient Name	Doctor and/or Hospital	Reason Seen	Date	Recovery Complete?

6. List all persons covered under your current plan who are eligible for coverage under another plan, including group plan, Medicare or Medicaid: ____________________

I certify that all statements contained herein are true to the best of my knowledge. **I understand that any misrepresentation, omission, or inaccurate information required herein shall prevent recovery under the policy if such answer is fraudulent or materially affects the risk assumed by Regence BlueShield of Idaho.** I understand this request will be underwritten to determine the extent of my eligibility, and that Regence BlueShield of Idaho will consider all medical information currently on file. I hereby expressly authorize any physician or hospital, or any other health care provider, to disclose to Regence BlueShield of Idaho any information obtained by having attended me or hereafter attending or examining me, and I understand that Regence BlueShield of Idaho will not disclose any information so obtained.

If you are applying for a limited Health Benefit Plan, please review your policy carefully.

Applicant's Signature ____________________ Date ____________

Social Security Number ____________________ Identification Number ____________

Street Address ____________________ Mailing Address ____________

Phone Number ____________