



# Regence Membership Maintenance Form

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

Failure to complete all applicable information may result in a delay in processing your membership changes.

Office Use	ID#:	
	Group#:	Eff Date:
	Comment:	

SUBSCRIBER/EMPLOYEE INFORMATION	<b>Instructions:</b>			
	<ul style="list-style-type: none"> <li>Please complete the appropriate section(s) below for reporting changes. If you are enrolling as a New Hire/Re-Hire or electing Open Enrollment options, please obtain an <b>Application for Membership</b> form from your Human Resource personnel.</li> <li>The form must be printed, signed, dated and submitted to Regence Blue Shield of Idaho through your Human Resource Personnel.</li> <li>Please retain a copy for your records.</li> </ul>			
	Last Name:	First Name:	MI:	Other Name, preference:
	SSN or Identification Number:		Gender:	Date of Birth (M/D/YYYY):
Current Group/Employer Name or Identification Number:				<input type="checkbox"/> I elect to decline coverage.

CHANGE	<b>Provide date of change and indicate event.</b>						
	Date Occurred (M/D/YYYY):	<input type="checkbox"/> Employee Married	<input type="checkbox"/> Dependent Married	<input type="checkbox"/> Divorce	<input type="checkbox"/> Birth	<input type="checkbox"/> Death	<input type="checkbox"/> Other:
	<input type="checkbox"/> Name Change from _____ to _____						
<input type="checkbox"/> Mailing Address:		City:	State:	Zip:	Phone:		

DEPENDENT ADDS/DELETES	✓	Dependent's Full Name	Relationship (Spouse, Son, Daughter, etc.)	Date of Birth (M/D/Y)	Social Security Number	Current or Prior Coverage for ADDITION of dependents				
						Carrier Name/Policy #	MEDICAL		DENTAL	
							Start M/D/Y	Stop M/D/Y	Start M/D/Y	Stop M/D/Y
<input type="checkbox"/> Add <input type="checkbox"/> Delete										
<input type="checkbox"/> Add <input type="checkbox"/> Delete										
<input type="checkbox"/> Add <input type="checkbox"/> Delete										
<input type="checkbox"/> Add <input type="checkbox"/> Delete										

SIGNATURE	I, the undersigned, hereby request the health care plan provider Regence BlueShield of Idaho, hereinafter known as "the Plan," to change my membership in the Plan as noted hereon, subject to prevailing rules, regulations and premiums of the Plan and in accordance with my present contract with the Plan. I understand any change in family status may affect my monthly premiums.	
	Signature:	Date of Signature: