



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
<p><i>Regence NowSelect is a limited health benefit plan. Please read your product brochure carefully for details.</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> \$1,000 Deductible <input type="checkbox"/> \$2,500 Deductible <input type="checkbox"/> \$5,000 Deductible <input type="checkbox"/> \$7,500 Deductible 	<ul style="list-style-type: none"> <input type="checkbox"/> \$2,500 Deductible <input type="checkbox"/> \$5,000 Deductible <input type="checkbox"/> \$7,500 Deductible 	<ul style="list-style-type: none"> <input type="checkbox"/> \$1,500 Deductible (Individuals Only) <input type="checkbox"/> \$2,500 Deductible (Individuals Only) <input type="checkbox"/> \$3,500 Deductible (Individuals Only) <input type="checkbox"/> \$3,000 Family Deductible (Families Only) <input type="checkbox"/> \$5,000 Family Deductible (Families Only) <input type="checkbox"/> \$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 _____