Blue Cross Blue Shield of Rhode Island

Plans for Individuals and Families
Medical Plan Option Change Form

EXISTING MEMBERS MAY USE THIS FORM TO REQUEST A MEDICAL PLAN CHANGE

Please be sure to complete ALL information below to avoid delays in processing.
If you have any questions, please call us at (401) 459-5000 or 1-800-639-2227.

Please print clearly using blue or black ink or type in information.

Section 1 Applicant Information

Last name ____________ M.I. ______ First name ____________ Suffix ______

Home address ______________ City/town ________ State ______ ZIP code ______

Mailing address ________________________________

Date of birth (mm/dd/yyyy) ___ / ___ / ______ Gender ☐ M ☐ F Social security number[1] ____-____-______

Current BCBSRI ID ____________ Home phone number ____-____-______ Cell phone number ____-____-______

What is your primary language spoken? ____________ E-mail address ____________

Race (please check one)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Multiracial ☐ Native Hawaiian or other Pacific Islander ☐ White

continued ➤

[1]Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html

Section 2 Medical Plan Options

I understand the options available and I hereby request the following coverage changes for myself and my dependents (if applicable):

Choose a Medical Plan Option (please check one):

Choose a **medical** contract type: ☐ Individual ☐ Family

Requested medical effective date (mm/dd/yyyy): ____ / ____ / ______

VantageBlue Direct	VantageBlue Direct with Dental	BlueSolutions for HSA Direct	BasicBlue Direct
☐ $1,000/2,000 Gold	☐ $1,200/2,400 Gold	☐ $1,400/2,800 Gold	☐ $2,750/5,500 Gold
☐ $3,000/6,000 Silver		☐ $3,900/7,800 Silver	☐ $4,900/9,800 Silver
		☐ $3,700/7,400 Bronze	☐ $6,850/13,700 Bronze
		☐ $5,350/10,700 Bronze	

BlueCHiP Direct

☐ $4,500/9,000 Silver

You are required to select a primary care physician for yourself and dependents (if applicable) for this plan.

Name	Date of birth (mm/dd/yyyy)	Primary care name, address
	___ / ___ / ______	
	___ / ___ / ______	
	___ / ___ / ______	
	___ / ___ / ______	
	___ / ___ / ______	
	___ / ___ / ______	

Cancellation

☐ Please check this box if you are canceling your current coverage with BCBSRI.

continued ➤

Section 3 TERMS, CONDITIONS, AND SIGNATURES

By signing this form, I acknowledge and agree that:

- I understand the medical plan benefits I have selected, including the deductible and out-of-pocket maximums.
- This change will not apply until the coverage is made effective by BCBSRI.
- Upon BCBSRI's approval, BCBSRI will send me new medical plan information and new ID cards.
- This medical plan change shall apply to me and all enrolled dependents.
- I am responsible for sharing benefit information with my enrolled family members covered under this policy.
- I certify that I have read the above statements or that they have been read to me and that the statements herein are true and complete to the best of my knowledge and belief.

____

Signature of Applicant or signature of parent or guardian *if applicant is under 18 years of age* — Date

Mail: Blue Cross & Blue Shield of Rhode Island
Membership Department
500 Exchange Street
Providence, Rhode Island 02903-2699

Or Fax: (401) 459-2385

For questions, call: (401) 459-5000 or 1-800-639-2227
Representatives are available Monday through Friday from 8:00 a.m. to 8:00 p.m.

500 Exchange Street • Providence, RI 02903-2699

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