



BlueLincs

Blue Cross and Blue Shield of Oklahoma

A Federally Qualified Health Maintenance Organization
PO BOX 21128 TULSA, OK 74121-1128

Request for Change in Membership

A Wholly Owned Subsidiary of Blue Cross and Blue Shield of Oklahoma,
a Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

OFFICE USE ONLY	MEMBER IDENTIFICATION NUMBER	GROUP NUMBER	EMPLOYER USE ONLY	REQUESTED EFFECTIVE DATE	DATE EMPLOYED FULL TIME (APPLICANT)
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PRINT IN INK OR TYPE CHECK APPROPRIATE BOX(ES):

<input type="checkbox"/> NAME OR ADDRESS CHANGE	<input type="checkbox"/> TERMINATION	<input type="checkbox"/> ADDING/DROPPING DEPENDENTS
COMPLETE ITEMS 1 THROUGH 3 AND 6	COMPLETE ITEMS 1 THROUGH 4 AND 6	COMPLETE ITEMS 1 THROUGH 3, 5 AND 6

1	MEMBER'S NAME (LAST) (FIRST) (MIDDLE)	NAME CHANGE	NEW NAME (LAST) (FIRST)	RESIDENCE TELEPHONE (A/C)
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2	ADDRESS (STREET OR BOX NO.) (CITY) (STATE) (ZIP)	SELECTED PRIMARY CARE PHYSICIAN	DATE OF BIRTH
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3	SOCIAL SECURITY OR MEDICARE NUMBER	I AM EMPLOYED BY (NAME OF COMPANY, CITY, STATE)	BUSINESS TELEPHONE (A/C)
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4 TERMINATION	<input type="checkbox"/> I REQUEST TERMINATION OF COVERAGE AS I AM NO LONGER EMPLOYED AS OF: MO. DAY YR.	<input type="checkbox"/> MOVED OUT OF SERVICE AREA	<input type="checkbox"/> I REQUEST TERMINATION OF COVERAGE WITHOUT LEAVING EMPLOYMENT AS OF: MO. DAY YR.
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YOU MUST SELECT A PRIMARY CARE PHYSICIAN FOR YOURSELF AND EACH FAMILY MEMBER WHO IS TO BE ENROLLED IN BLUELINC'S HMO. SELECT ANY PRIMARY CARE PHYSICIAN ON THE PROVIDED LIST THAT IS CURRENTLY ACCEPTING MEMBERS. INDICATE THE PHYSICIAN'S FULL NAME.

5 ADDING / DROPPING DEPENDENTS

<input type="checkbox"/> ADD <input type="checkbox"/> DROP	FULL NAME OF SPOUSE (FIRST, MIDDLE, LAST)	MARRIAGE DATE MO. DAY YR.	DATE OF BIRTH MO. DAY YR.	SPOUSE'S SOC. SEC. NO.	IF ADDED OR DROPPED, GIVE REASON AND DATE OF: <input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> BIRTH <input type="checkbox"/> MARRIAGE <input type="checkbox"/> ADOPTION (need court papers) <input type="checkbox"/> LOSS OF OTHER COVERAGE (provide certificate of coverage) <input type="checkbox"/> OTHER (reason below):
SPOUSE'S EMPLOYER (NAME OF COMPANY)	COVERED BY OTHER GROUP HEALTH INSURANCE? YES NO	IF YES, INSURANCE CO. NAME	SELECTED PRIMARY CARE PHYSICIAN FOR SPOUSE	MO. DAY YR.	

<input type="checkbox"/> ADD <input type="checkbox"/> DROP	DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST)	SEX M F	RELATIONSHIP TO MEMBER	DATE OF BIRTH MO. DAY YR.	SELECTED PRIMARY CARE PHYSICIAN FOR DEPENDENT
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IS DEPENDENT A FULL TIME STUDENT IN AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY? IF YES, NAME OF INSTITUTION AND ATTACH CLASS SCHEDULE WITH HOURS	IF DEPENDENT ADDED OR DROPPED, GIVE REASON AND DATE OF: <input type="checkbox"/> DEATH <input type="checkbox"/> DIVORCE <input type="checkbox"/> BIRTH <input type="checkbox"/> MARRIAGE <input type="checkbox"/> ADOPTION (need court papers) <input type="checkbox"/> LOSS OF OTHER COVERAGE (provide certificate of coverage) <input type="checkbox"/> OTHER (give reason below):
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COVERED BY OTHER GROUP HEALTH INSURANCE?	IF YES, INSURANCE COMPANY NAME	SOCIAL SECURITY NO. (IF ISSUED)	MO. DAY YR.
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THE AUTHORIZATION BELOW MUST BE SIGNED AND DATED

6	I agree to pay the membership charges to BlueLincs HMO. If my membership is with an employer group, I authorize my employer, as my agent, to deduct the amount of charges from my wages or salary and forward the payments to BlueLincs HMO. I represent the above information to be complete and accurate to the best of my knowledge.	AUTHORIZATION TO RELEASE AND FURNISH MEDICAL RECORDS Physicians, practitioners, hospitals and other institutions are hereby authorized and have my consent to release and furnish to BlueLincs HMO, any and all information, records or copies of records relating to my or my eligible dependents medical history and conditions, including, but not limited to, diagnosis, treatment, care, surgery, and the dates thereof.	
SIGNATURE OF APPLICANT	DATE OF APPLICATION MO. DAY YR.	SIGNATURE OF SPOUSE	DATE OF APPLICATION MO. DAY YR.