HIGHMARK® HEALTH INSURANCE COMPANY

CHANGE REQUEST

If you are enrolled in an individual plan that you purchased directly from Highmark and NOT through the Health Insurance Marketplace, you can use this form to make certain changes to your current enrollment, including a name or address change, correcting a birth date or adding a spouse/domestic partner or dependent. All changes must be made within 60 days of the event occurring. Informational changes, such as birthdate corrections, should be made as soon as the inaccuracy is discovered. **You CANNOT change your plan using this form.**

If you would like to know more about Special Enrollment Periods* or changing plans due to a qualifying life event, you can call our Help Center at 1-877-959-2550, visit your insurance agent or one of our retail locations.

Be sure to check the box next to the change(s) you are submitting and provide all the information requested in that section. **Sign and return this form by mail to Highmark Health Insurance Company, P.O. Box 382061, Pittsburgh, PA 15251-8061 or fax to 1-866-224-5403 or email to DP_Applications@highmark.com.**

POLICYHOLDER HOLDER

First Name	Middle Name	Last Name & Suffix
Social Security Number	Group Number	

☐ ADDRESS CHANGE (Requests must be reported within 60 days from when the event occurred.)

Home Address			
City	State	Zip Code	County
Mailing Address (*if different from home address*)			Apartment Number
City	State	Zip Code	County

☐ NAME CHANGE OR CORRECTION (Requests must be reported within 60 days from when the event occurred.)

First Name	Middle Name	Last Name & Suffix
Date of Change	Reason For Change	

☐ BIRTH DATE CORRECTION (Correcting a birth date may result in a rate change if it places you in a different rate category.)

First Name	Middle Name	Last Name & Suffix	Date of Birth (month/day/year)

☐ ADDING A SPOUSE/DOMESTIC PARTNER ☐ DELETING A SPOUSE/DOMESTIC PARTNER

When adding or deleting a Spouse/Domestic Partner, the effective date will be the first of the following month in which the request was received. Requests must be received within 60 days from when the event occurred.

First Name	Middle Name	Last Name & Suffix
Sex ❑ Male ❑ Female	Date of Event (month/day/year)	Date of Birth (month/day/year)

Dependents 18 years of age or older have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No

If "Yes," when was the last time you used tobacco regularly? _____/_____/_____ (Month/Day/Year)

* A Special Enrollment Period is defined as the time during which you and your family can sign up for a new plan or make changes to existing health insurance coverage if you have a qualifying life event. Examples of qualifying life events are certain permanent moves, certain changes in your income, and changes in your family size (such as if you marry, enter into a civil union or domestic partnership, divorce, or have a baby).

ADDING A DEPENDENT - Newborn, adopted, placement for adoption or placement in foster care must be within 60 days from when the event occurred. The effective date will be the date of birth, adoption, placement for adoption or foster care.

DELETING A CONTRACT HOLDER OR DEPENDENT - Deletion will be effective the first of following month in which the request was received.

First Name, Middle Name, Last Name & Suffix ❑ DELETE	Sex ❑ Male ❑ Female	❑ **CONTRACT HOLDER**	Date of Birth (month/day/year) Date of Event (month/day/year)
First Name, Middle Name, Last Name & Suffix ❑ ADD ❑ DELETE	Sex ❑ Male ❑ Female	❑ **DEPENDENT**	Date of Birth (month/day/year) Date of Event (month/day/year)

Dependents 18 years of age or older have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No

If "Yes," when was the last time you used tobacco regularly? ______/______/______ (Month/Day/Year)

First Name, Middle Name, Last Name & Suffix ❑ ADD ❑ DELETE	Sex ❑ Male ❑ Female	❑ **DEPENDENT**	Date of Birth (month/day/year) Date of Event (month/day/year)

Dependents 18 years of age or older have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No

If "Yes," when was the last time you used tobacco regularly? ______/______/______ (Month/Day/Year)

First Name, Middle Name, Last Name & Suffix ❑ ADD ❑ DELETE	Sex ❑ Male ❑ Female	❑ **DEPENDENT**	Date of Birth (month/day/year) Date of Event (month/day/year)

Dependents 18 years of age or older have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No

If "Yes," when was the last time you used tobacco regularly? ______/______/______ (Month/Day/Year)

Highmark is committed to providing outstanding services for our applicants and members. If you need assistance because you have a disability or if you have limited English proficiency, please call 1-800-876-7639 or TTY at #711 to receive assistance free of charge.

To the best of my knowledge and belief, the information provided on this Change Request Form is true and correct.

I also understand that any attempts to make a change to current enrollment through fraud or other intentional misrepresentation of a material fact will result in termination of such contract.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

POLICYHOLDER'S SIGNATURE	DATE

NOTICE TO ALL POLICYHOLDERS: To make changes you must sign this Change Request Form. If you are unmarried, under age 18 and making a change to individual coverage, a parent or guardian must sign.

THIS CHANGE REQUEST FORM IS VALID ONLY WHEN COMPLETED AND SIGNED BY THE POLICYHOLDER.

FOR PRODUCER USE ONLY	
Print Producer Name	
Producer Signature	Date

By signing this Change Request Form I do hereby attest, acknowledge, and agree to the following:

- The Policyholder has designated me as their authorized representative in compliance with all applicable state and federal laws,rules, regulations and guidelines;
- I have read this Change Request Form to the Policyholder required to sign this Form and such Policyholder ACCEPTS the terms and conditions set forth in this Form;
- I will immediately send a copy of this completed and submitted Change Request Form to the Policyholder in a secure manner in compliance with all applicable state and federal laws, rules, regulations and guidelines; and
- I have retained a copy of this completed and submitted Change Request Form for my records.

Blue Cross Blue Shield Agency No.							Producer No.							