WASHINGTON • SARATOGA

BOCES

BOARD OF COOPERATIVE EDUCATIONAL SERVICES

WARREN • HAMILTON • ESSEX

Empire Blue Cross Health Insurance Enrollment change form

Date_____

Subscriber Member ID Number:_____ District_____

Subscriber Name_____ Date of Birth_____

☐ **Send ID Card (s)** Dependent Member Name_____

☐ **Delete Subscriber, Spouse & Dependents**
Effective_____ Reason Code*_____

☐ **Changes to Subscriber** (enter only corrected data)
Name_____ Date of Birth_____
Address_____ Martial Status_____
City_____ Spouse's Health Insurance_____
Zip Code_____ Spouse's ID number_____
Home Telephone Number_____ Alternate Telephone Number_____

☐ **Delete Spouse or Dependent**
Dependent Name_____ ID Number_____
Effective Date_____ Reason Code*_____

☐ **Add or Change Spouse or Dependent**
Dependent Name_____ ID Number_____
Date of Birth_____ Sex M or F
Effective Date_____ Reason Code*_____

☐ **Reactivate Subscriber**
Effective Date_____

☐ **Reactivate Spouse or Dependent**
Dependent Name_____ ID Number_____
Effective Date_____ Reason Code*_____

☐ **Change Plan**
From_____ To_____
Effective_____

Applicant signature_____ GBA signature_____

***Reason Codes**

1 Termination of Employment
2 Birth/Adoption
3 Dependent over age
4 Student Status change
5 Marriage/Divorce
6 Per Member
7 Opting for other coverage
8 Other_____ (please specify)
9 Death

BCO's use only

Date processed_____

Initials_____