BlueCross BlueShield of Texas

Request for Change in Membership

Please complete this form to become the Primary Policyholder with no other change in coverage.

- Please complete all fields that apply and sign and date the form in Part 2.
- If the current primary applicant wants to cancel their policy when this request is processed, their signature is required in part 2.

PART 1 — PRIMARY APPLICANT INFORMATION (please print)

First Name	Middle Initial	Last Name	Date of Birth (mm/dd/yyyy)	Sex M F

Residential Street Address (no P.O. Boxes)	City / State / ZIP
County	E-mail
Home Phone	Work Phone

1. TOBACCO USE STATUS Have you, your spouse, if insured, or dependent child(ren) smoked or used tobacco in any form in the last 12 months?
Applicant ☐ Yes ☐ No **Spouse or Dependent Children** ☐ Yes ☐ No

2. PRIMARY POLICYHOLDER OF CURRENT POLICY _____

Social Security No. _____ - _____ - _____ **Identification No.** _____

3. DEPENDENT CHILDREN
Note: You may change coverage only for children under 26 years of age who are now covered under the current Blue Cross and Blue Shield of Texas (BCBSTX) health insurance policy. List all children this application applies to.

Names of Dependent Children Enrolled	Age	Tobacco User
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

BILLING ADDRESS If the billing address is different from above, please print it here:

_____

PART 2 — REPRESENTATIONS AND ACKNOWLEDGEMENTS

I apply for coverage as indicated for which I am eligible with Blue Cross and Blue Shield of Texas.

I have been informed of the provisions of the Blue Cross and Blue Shield of Texas health plans.

I understand that the insurance plan applied for is not an employer-sponsored group health plan and does not comply with state or federal small employer laws.

I know that any fraudulent misstatements or omissions, or intentional misrepresentations of a material fact that are made on this application or any act or practice that constitutes fraud, will result in the cancellation of my or my spouse's and/or dependent child(ren)'s coverage retroactive to the effective date of coverage subject to prior notification.

Primary Applicant's Signature (Age 19 and Over)	**Date**
Parent Or Legal Guardian's Signature (If Primary Applicant Is Under Age 18)	**Date**

If this authorization is signed by a personal representative on behalf of an individual (other than a parent for a minor child), complete the following:		
Personal Representative's Name **(Please Print)**	**Relationship**	**Date**

If the primary insured of the original policy wants to cancel the coverage once the request is completed, please sign below:	
Signature	**Date**

PART 3 — PROXY STATEMENT

By purchasing a BCBSTX health plan, I become a member of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). By signing this Application, I ask the Board of Directors of HCSC to act on my behalf at all meetings of members of HCSC. I understand that:

- This permission will apply to any company that replaces HCSC
- The Board of Directors may appoint someone to vote for me

The annual meeting of members is scheduled to take place each year in the corporate headquarters (300 E. Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called if needed. Notice of any special meeting will be given within 30 to 60 days before the meeting.

My assignment of my member vote to the Board of Directors will be in effect:

- Until or if I cancel it in writing at least 20 days before any meeting of members, or
- Unless I attend and vote in person at any meeting of members

Primary Applicant's Proxy Signature	**Date**
Print Your Name as You Signed It:	

Please submit this form by:

MAIL	Blue Cross and Blue Shield of Texas, Attn: Individual Enrollment, PO Box 660819, Dallas, TX 75266-0819
FAX	**800-279-7419**

Questions? If you have any questions, please call your independent, authorized agent or call BCBSTX toll-free at **888-697-0683**.

Changes in state or federal law, or regulations or interpretations thereof, may change the terms and conditions of coverage.