

BCN Individual Change of Status Form

Subscriber Name	Group Number	Contract No
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Membership Changes (Excludes Medigap)

- Add the following person(s) to my contract (must be notified within 30 days of event):
Reason: Marriage Birth Other _____
- Remove the following person(s) from my contract:
Reason: Death Divorce Other _____

Last Name	First Name	M.I.	Sex	Date of Birth (MM/DD/YYYY)	Social Security Number	Date of Event	*Rel. Code
Spouse							
Dependent							
Dependent							

***Relationship Codes**
 N – Biological/Adopted Child
 S – Stepchild
 A – Child Adoption in Progress (Attach Court Document)
 D – Disabled Child (PA275) (Attach Physician Statement)
 L – Legal Guardianship (Attach Court Document)
 P – Principal Support (Attach Court Document)
 C – Court Order Coverage (QMSCO) (Attach Court Document)

Other Changes

New Name

Last Name	First Name	Middle Initial
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New Address

Address		
City	State	Zip Code

New Telephone Number

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- Cancel my BCN 65 prescription drug coverage only.
- Cancel my contract on the next scheduled termination date following the receipt of this request. We need 30 days written notification and your signature below to process the contract cancellation.

Subscriber's Signature _____
Date

Agent Code	MA/GA Code	Assn/Chamber	Managing Agent/General Agent/Agent Signature

Fax change request form to 1-877-218-1466