

**MEMBER PLAN TRANSFER FORM**

**Current Blue Shield individual and family plan (IFP) members are eligible to transfer without underwriting to selected health plans. To submit your transfer request, please complete, sign, and return this form to: Blue Shield, P.O. Box 629013, El Dorado Hills, CA 95762-9013, Fax No.: (916) 350-7500.**

This form must be typed or completed in blue or black ink. Do not include dues/premiums. For help filling out this form or if you have questions about your plan options, call Blue Shield at **(800) 431-2809** or contact your agent or broker.

**Part 1 – Subscriber information (found on your Blue Shield identification card)**

Subscriber Name	Subscriber Number	Group Number
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**Part 2 – Plan selection**

Find your current plan below. If the plan you would like to transfer to is listed in the same column and lower on the list, check its box (one box only). All members on a family plan contract/policy must transfer to the same plan.

**To transfer to a plan higher on the list or in a different column (subject to underwriting), please use the Subscriber IFP Plan Change Request Form (C12278).**

Blue Shield of California Plans	Blue Shield of California Life & Health Insurance Company Plans
Preferred Plan 250 <sup>1</sup>	Active Start Plan 25 <sup>2</sup>
Personal HMO <sup>1</sup>	<input type="checkbox"/> Active Start Plan 35 <sup>2</sup>
Preferred Plan 500 <sup>1</sup>	<input type="checkbox"/> Active Start Plan 25 Generic Rx <sup>2,3</sup>
Preferred Special Plan 500 <sup>1</sup>	<input type="checkbox"/> Active Start Plan 35 Generic Rx <sup>2,3</sup>
Blue Shield HMO <sup>1</sup>	<input type="checkbox"/> Essential Plan 1750 <sup>2,3</sup>
Preferred Plan 750 <sup>1</sup>	<input type="checkbox"/> Blue Shield Life PPO Plan 1500
Preferred Special Plan 750 <sup>1</sup>	<input type="checkbox"/> Balance Plan 1000 <sup>2,3</sup>
<input type="checkbox"/> Access+ HMO	<input type="checkbox"/> Blue Shield Life PPO Plan 2000
Coronet Major Benefits Plus 1000 <sup>1</sup>	<input type="checkbox"/> Balance Plan 1700 <sup>2,3</sup>
Preferred Plan 1000 <sup>1</sup>	<input type="checkbox"/> Essential Plan 3000 <sup>2</sup>
<input type="checkbox"/> Shield Spectrum PPO Plan 500	<input type="checkbox"/> Balance Plan 2500 <sup>2,3</sup>
Preferred Plan 1250 <sup>1</sup>	<input type="checkbox"/> Essential Plan 4500 <sup>2</sup>
<input type="checkbox"/> Access+ Value HMO	<input type="checkbox"/> Shield Spectrum PPO Savings Plan 4000/8000
<input type="checkbox"/> Shield Spectrum PPO Plan 750	<input type="checkbox"/> Shield Spectrum PPO Plan 5000
Preferred Plan 1500 <sup>1</sup>	<input type="checkbox"/> Vital Shield 2900 <sup>2,3</sup>
<input type="checkbox"/> Shield Spectrum PPO Plan 1500	
Coronet Major Benefit Plus 2000 <sup>1</sup>	
Preferred Plan 2000 <sup>1</sup>	
Preferred Special Plan 2000 <sup>1</sup>	
<input type="checkbox"/> Shield Spectrum PPO Savings Plan 2400/4800	
<input type="checkbox"/> Shield Spectrum PPO Plan 2000	

- 1 This plan is not available to new members, but members may transfer out of this plan into a plan that is available to new members and that is lower on the list.
- 2 This plan does not include maternity benefits.
- 3 Pending regulatory approval.

**Part 3 – HMOs only: Complete this section if you are requesting a transfer to one of our HMO plans and/or changing your Personal Physician selection**

HMOs are available only in those Plan Service Areas specified in the *Blue Shield HMO Physician and Hospital Directory*, available at [blueshieldca.com](http://blueshieldca.com). Subscriber must live or work in an HMO Plan Service Area. Select a Personal Physician for yourself and each of your eligible family members from the list of Personal Physicians in the *Blue Shield HMO Physician and Hospital Directory* for your service area. You may choose the same or a different Blue Shield HMO Personal Physician for each family member. Be sure to include each Personal Physician's provider number as listed in the directory.

Relationship	First Name	Personal Physician Name	Provider No.	Current Patient
Self: <input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Domestic Partner				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Yes <input type="checkbox"/> No

**Part 4 – Authorizations, terms, and conditions**

In addition to the terms and conditions for individual and family plan coverage previously agreed upon, the following apply. Please read carefully. Your authorization and signature are required below.

1. Members who have been enrolled in an underwritten Individual and Family plan for a continuous 12-month period are eligible for a non-underwritten transfer.
2. When your request to transfer plans is approved, Blue Shield will assign an effective date of change. Until you receive notification that your request is approved, you should maintain your current coverage and continue making payments on your current plan.
3. The rate for your new plan will be at the comparable tier as for your current plan. Requests to transfer back to your original plan are subject to underwriting. However, if you transfer out of a plan that is not available to new members, you cannot transfer back to it.
4. When approved, this Member Plan Transfer Form, together with the original Application for Blue Shield Individual and Family Health Plans, *Evidence of Coverage and Health Service Agreement/Policy*, any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage. Your agent or broker cannot approve this form or change any terms or conditions of coverage.

I have read the summary of benefits and understand and agree to each of the terms and conditions of coverage for the health plan I am requesting.

All members 18 and older must sign and date this form. Keep a copy of this form for your records.

X _____ Signature of Subscriber/Parent (or Legal Guardian)	_____ Today's Date (required)	_____ Print Name (and relationship if subscriber is a minor)
X _____ Signature of Subscriber's Spouse/Domestic Partner (if applicable)	_____ Today's Date (required)	_____ Print Name
X _____ Signature of Family Member Age 18 and Over (if applicable)	_____ Today's Date (required)	_____ Print Name
X _____ Signature of Family Member Age 18 and Over (if applicable)	_____ Today's Date (required)	_____ Print Name